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**FISCAL POLICY IMPLICATIONS OF THE 1988
MEDICARE CATASTROPHIC COVERAGE ACT**

by

James K. Flynn

December 1997

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Congress passed the 1988 Medicare Catastrophic Coverage Act (MCCA) in an effort to provide seniors with protection from catastrophic medical costs. The MCCA marked a turning point in Medicare policy. It sought to expand Medicare by requiring the beneficiaries themselves to fund the added benefits to the program through increased premiums and linking the size of the increase to beneficiary income. The MCCA was largely financed by middle and upper income beneficiaries. Enacted on July 1, 1988, the MCCA was repealed 17 months later on November 22, 1989, due to controversy and opposition from senior citizens concerned about its financing and lack of long-term care benefits. This thesis examines the fiscal and political environment that led to the genesis, evolution, passage, and repeal of the MCCA. The legislative process and the financing mechanisms of the MCCA are examined within a political context dominated by the need to reduce spending and balance the budget. Data was obtained from congressional documents, periodicals, journals, and Office of Management and Budget, Congressional Budget Office, and Health Care Financing Administration documentation. The MCCA failed because of strong opposition from senior citizens and lobby groups regarding its means-tested financing and lack of long-term care. The complexity of the MCCA caused public misunderstanding and permitted opposition groups to promote misinformation concerning the bill and the Medicare program.

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COVERAGE ACT**

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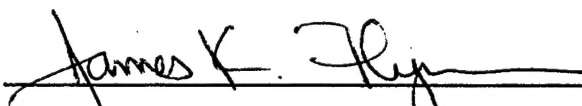
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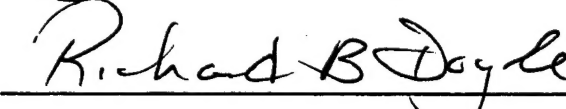
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ABSTRACT

Congress passed the 1988 Medicare Catastrophic Coverage Act (MCCA) in an effort to provide seniors with protection from catastrophic medical costs. The MCCA marked a turning point in Medicare policy. It sought to expand Medicare by requiring the beneficiaries themselves to fund the added benefits to the program through increased premiums and linking the size of the increase to beneficiary income. The MCCA was largely financed by middle and upper income beneficiaries. Enacted on July 1, 1988, the MCCA was repealed 17 months later on November 22, 1989, due to controversy and opposition from senior citizens concerned about its financing and lack of long-term care benefits. This thesis examines the fiscal and political environment that led to the genesis, evolution, passage, and repeal of the MCCA. The legislative process and the financing mechanisms of the MCCA are examined within a political context dominated by the need to reduce spending and balance the budget. Data was obtained from congressional documents, periodicals, journals, and Office of Management and Budget, Congressional Budget Office, and Health Care Financing Administration documentation. The MCCA failed because of strong opposition from senior citizens and lobby groups regarding its means-tested financing and lack of long-term care. The complexity of the MCCA caused public misunderstanding and permitted opposition groups to promote misinformation concerning the bill and the Medicare program.

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I. INTRODUCTION

Victory has one hundred fathers and defeat is an orphan.

- John F. Kennedy, after the failure of the Bay of Pigs Invasion
(Johnson and Broder, 1996)

A. BACKGROUND

1. Medicare Catastrophic Coverage Act

The 100th Congress passed the 1988 Medicare Catastrophic Coverage Act (MCCA) in an effort to provide seniors with protection from catastrophic medical costs. The bill was signed into law by President Reagan on July 1, 1988 (P.L. 100-360). The MCCA was then repealed by Congress on November 22, 1989, only seventeen months after it was enacted. The controversial program became politically unpopular after thousands of senior citizens protested having to pay a surtax and higher monthly premiums to finance the new Medicare benefits. Despite efforts by both political parties to save the MCCA, political considerations forced its demise.

The MCCA marked a turning point in Medicare policy. It sought to expand Medicare benefits by requiring beneficiaries themselves to fund the additions to the program. The MCCA was also the first attempt at changing the fundamental financing mechanisms. The MCCA was largely financed by middle and upper income beneficiaries (i.e., it was means-tested). The financing of MCCA became the most controversial aspect of this legislation and the primary reason for its repeal in 1989.

This year in the 105th Congress, the Senate made an unexpected proposal to means-test Medicare Part B premiums as a deficit reduction and Medicare reform initiative. Even though this initiative was backed by the President, the Senate and 60 percent of the public surveyed (Mintz, 1997, p. 1788), it was dropped from the final bill. Some veteran members of Congress remember the repeal of the MCCA and most House Republicans remember the bashing that they took from the Democrats for their plan to cut Medicare in the 1995-1996 budgets. They were fearful of constituent backlash and criticism from the Democrats in Congress for going too far with Medicare changes this year. Although politically sensitive, alternative methods for Medicare financing such as means-testing appear to be gaining a larger support base and will undoubtedly resurface in future Medicare reform debates.

Financing was the short term problem for MCCA and financing is also the long term problem that jeopardizes Medicare solvency in the twenty-first century. Medicare expenditures currently exceed income. As a result, the Hospital Insurance (HI) Trust Fund which pays for inpatient hospital and related care will be insolvent by 2001 (Economic Report of the President, 1997, p. 17).

Since its inception in 1965, Medicare has been an extremely successful program, providing medical care to the aged and later the disabled. Medicare's popularity, coupled with rapid increases in the cost of health care, has caused it to become increasingly burdensome to the federal budget, particularly when Congress is attempting to balance the budget while cutting spending. From 1975 to 1995, Medicare enrollment as a percentage

of the population increased from 10.8 to 13.6. Additionally, Medicare net federal spending (outlays minus premium receipts) as a percentage of the budget increased from 4.6 to 10.0, while Medicare net spending as a percentage of Gross Domestic Product (GDP) increased from 1.0 to 2.3. If no changes were made in current law, Medicare net spending is expected to reach 4.1 percent of GDP by 2010, and 7.1 percent by 2030, when most of the baby boomer generation reaches retirement (CBO, "Long Term Budgetary Pressures and Policy Options," 1997, p. 37). Medicare has been a major contributor to the federal deficit and has become a centerpiece of federal budget reform and deficit reduction initiatives since the mid 1980's.

Prior to passage of MCCA, the last major addition to Medicare was in 1972, when disabled persons and persons with end stage renal disease (ESRD) were added to the program. In 1986, the Bowen Commission issued a report recommending expanding Medicare to limit beneficiaries' out-of-pocket costs to \$2,000 per year for extended hospital stays (Rovner, 1986, p. 2956). The Bowen Report laid the groundwork for the MCCA. After years of cost cutting, this bill sought to expand Medicare benefits with the stipulation from President Reagan that any changes had to be budget neutral. Although MCCA began as a relatively simple proposal, due to numerous political pressures it became an extremely complex Medicare reform bill.

When the MCCA passed in 1988, it made additions or reforms in eight areas of Medicare: hospital care, skilled nursing care, home health care, a limit on Part B copayments, hospice care, respite care, mammograms, and prescription drugs (Moon,

1996, p. 130). MCCA was designed from the outset to fully fund 100 percent of these additional benefits by increased beneficiary payments. The financing for MCCA came from two sources. First, the existing flat Part B premium was raised \$4 per month from \$24.80 (1988), to \$28.80 for an annual increase of \$48 per year. Second, there was a Part A mandatory supplemental premium (effectively a 15 percent surtax) that was based on income and ranged from \$22.50 to \$800 per year in 1988. Estimates indicated that only 5 percent of the beneficiaries would be subject to the maximum tax level of \$800, and that about 40 percent of the elderly would pay at least some supplemental premium. This surtax would rise rapidly over time to a maximum of 28 percent in 1993, and range from \$42 to \$1050 per year in 1993 (Moon, 1996, p. 119). This means-tested supplemental premium would later cause the most problems for MCCA.

The MCCA quickly became highly controversial for several reasons. First, as mentioned previously, it was means-tested. This was the first instance in which Medicare beneficiary contributions were linked to their ability to pay. Heretofore, Medicare was a universal entitlement. Second, its financing was front loaded to build up a surplus, while several of the benefits were delayed for a year or two. Although this approach made good fiscal sense, its merits were not understood by the elderly. This financing plan caused further criticism and protest in the spring of 1989 when the Treasury announced that the collections from the supplemental premium were much higher than expected, generating a large surplus. Third, it was very complex and its benefits were not well understood. Fourth, it duplicated benefits in medigap policies that many beneficiaries already had

through government or private retiree programs. Fourth, the benefits were spread so thinly that they seemed of minimal value to the average beneficiary. Finally, soon after passage, it became apparent that the costs were higher than expected and that it would not pay for itself, as originally stipulated (Moon, 1995, p. 125).

The politics surrounding MCCA reflected several health care issues that will continue to surface in future Medicare reform, i.e., acute vs. long-term care, universal vs. means-tested benefits, general vs. specialized health care plans, and defined benefit vs. defined contribution programs. Finally, the MCCA experience emphasized the dynamic relationship between public and private health care systems, the need for a more user-friendly system, and the fact that small benefit increases may result in large cost increases.

2. Medicare Program

a. Enactment

The Medicare program was signed into law by President Lyndon B. Johnson on July 30, 1965 and went into effect on July 1, 1966. For many years prior to Medicare, universal health coverage was the goal of social reformers. These reforms were opposed by provider groups (principally the American Medical Association) that did not want government provision of health care. The compromise was coverage for elderly citizens over the age of 65. The elderly were a natural group to ensure since only about 50 percent of them had health insurance coverage (Cutler, 1997, p. 198).

Medicare was set up somewhat similar to existing private health insurance plans with services divided into two parts, hospital care (Part A), and physician and

outpatient care (Part B). Medicare's structure, like many other government programs, was also due to political compromise. Part A, the compulsory health insurance for everyone, was pushed by the Democrats. Part B, the voluntary part, was pushed by Republicans, who wanted to stave off National Health Insurance. Political support was ensured by combining the two parts of Medicare with a third proposal, to create the Medicaid program for poor people. "That produced a program that made political sense but was otherwise quite confusing - an element that would come back to haunt policymakers during the fight over the catastrophic coverage law," (Rovner, 1995, p. 148).

b. Part A

Medicare Part A (Hospital Insurance) originally covered inpatient hospital services, some skilled nursing facilities, home health care, and hospice care. Part A is financed by a 2.9 percent payroll (FICA) tax, shared equally by employers and employees (self-employed workers pay 2.9 percent). A trust fund account was set up by the U.S. Treasury to hold Medicare premiums and income to pay benefits and program costs for Part A, called the Hospital Insurance (HI) Trust Fund. There is a similar trust fund for Part B, called the Supplementary Medical Insurance (SMI) Trust Fund. The trust funds hold money not needed to pay benefits and administrative costs and, by law, invest it in special Treasury bonds that are guaranteed by the U.S. Government. Historically, trust fund revenues have exceeded costs, but in 1995 this trend reversed for the HI Trust Fund, which is now running a negative balance (Kellison and Moon, 1997, p. 5).

In their annual reports, the Trustees of the Social Security and Medicare trust funds publish projections of the systems' revenues and outlays for the next 75 years. Although these projections are highly uncertain given the time horizon and the difficulty in estimating future medical costs, they are nevertheless, the best available estimates. In the short-term, the HI Trust Fund is declining rapidly, and will be exhausted in 2001. In the long-term, as a percentage of GDP, Part A expenditures are projected to almost triple in the next 75 years, expanding from 1.7 to 5.0, a 183 percent rate of increase. By comparison, Social Security and Disability Insurance expenditures are anticipated to increase from 4.0 to 5.8 percent of GDP during the same period, a 44 percent rate of increase (Kellison and Moon, 1997, pp. 3-10).

c. Part B

Medicare Part B (Supplementary Medical Insurance) covers primarily physician and outpatient services. Although this is an optional plan, 96 percent of those in Part A are also enrolled in Part B (President's Budget Proposal, 1997, p. 185). Part B (SMI) is financed by monthly premiums charged beneficiaries (\$43.80 in 1997) and by payments from federal general revenues. In 1996, SMI premiums accounted for only 22 percent (\$19 billion) of Part B costs and interest income covered 2 percent (\$1.8 billion). The remainder of Part B costs, 76 percent (\$65 billion), were funded by general revenue payments (Kellison and Moon, 1997, p. 3). The SMI Trust Fund, which pays doctor bills and other outpatient expenses, is financed on a year-by-year basis and trust fund income is projected to equal expenditures for all years, but only because beneficiary premiums and

government revenue contributions are automatically set to meet expected costs each year (Kellison and Moon, 1997, p. 11). Therefore the SMI Trust Fund will be able to cover costs and appears to be financially stable, in the short-term.

The problem for the SMI Trust Fund is in the long-term because of its fast growth rate and expected large cost increases associated with the baby boom generation's retirement. In the long-term, as a percentage of GDP, Part B expenditures are projected to more than triple in the next 75 years from 0.97 to 3.42. Although total dollar costs for SMI are smaller than HI, SMI's faster rate of growth over the next 75 years (253 percent versus 183 percent for HI) creates serious concerns about long-term financing for Medicare Part B (Kellison and Moon, 1997, p. 10).

d. Perceptions are Reality

Central to this thesis is the notion that soon after Medicare was established in 1965, the beneficiary population began to regard Medicare as an earned "entitlement." Like Social Security, they strongly believe that they have paid for Medicare by contributing with their payroll taxes throughout their working lives and therefore feel that they are entitled to their benefits. Most of the current beneficiaries don't make distinctions between different funding streams for entitlement programs (Wildavsky, 1997, p. 1511). Specifically, many don't understand that Part A and Part B are funded differently. They therefore view any increase in premiums as being "gouged" for something for which they have already paid throughout their working lives.

The critical distinction often overlooked is that only Part A receives funding from worker payroll taxes and is automatic, just like Social Security. Part B, on the other hand, is optional and funded by a beneficiary premium which covers 25 percent of the costs; the remainder is funded by general revenues. The Trust Funds probably further add to the beneficiaries' misconception that the dollars they have paid into this program are set aside to pay for their retirement and health care benefits after age 65.

B. MEDICARE AND THE FEDERAL BUDGET

1. Health Care Spending

Medicare is the largest public health care program in the United States, covering over 38 million elderly, disabled and ESRD afflicted Americans. The program will spend an estimated \$211 billion in 1998, compared to \$174 billion (actual) in 1996 (President's Budget Proposal, 1997, p. 185). For 1998, the Congressional Budget Office (CBO) estimates that Medicare spending will be 2.7 percent of GDP, and the average annual growth rate from 1997 to 2002 will be 8.5 percent (CBO, "Analysis of the President's Budgetary Proposals for Fiscal Year 1998," 1997, p. 27).

By comparison, Medicaid covers over 37 million low-income elderly and poor Americans. Medicaid will spend an estimated \$107 billion (federal dollars) in 1998, compared to \$92 billion (actual) in 1996 (President's Budget Proposal 1997, p. 181). For 1998, CBO estimates that Medicaid spending will be 1.3 percent of GDP and the average annual rate of growth from 1997 to 2002 will be 7.8 percent (CBO, "Analysis of the President's Budgetary Proposals for FY 1998," 1997, p. 30). Medicaid is a federal-state

health care program, with the federal government providing, on average, 57 percent of the total cost and the states providing 43 percent (President's Budget Proposal, 1997, p. 181).

Under current policy, Medicare and Medicaid combined spending as a percentage of GDP will increase from 3.9 in 1997 to 5.5 in 2007, whereas total federal revenues will decrease from 19.3 to 18.8 over the same period (CBO, "Reducing the Deficit," 1997, p. 2). Additionally, from 1997 to 2007, Medicare spending alone will grow at an average annual rate of 8.3 percent, compared with the projected 4.7 percent growth in the economy over the same period (CBO, "Reducing the Deficit," 1997, p. 296).

Health care costs are currently growing at almost twice the rate of the economy while federal revenues have historically stayed between 18 and 19 percent of GDP. Consequently, the country will spend a larger percentage of its personal income and also a larger percentage of the federal budget on health care. When the baby boomers start to retire around 2010, the number of people receiving benefits will increase rapidly, while the number of workers paying payroll taxes grows more slowly.

2. Entitlement Spending

Entitlement spending (not including net interest) is currently the largest segment of the federal budget, at 59 percent of total federal spending for 1997. From 1997 to 2002, CBO estimates that mandatory spending will increase from 59 to 66 percent and discretionary spending will decrease from 36 to 31 percent over the same period (CBO, "Analysis of the President's Budgetary Proposals for Fiscal Year 1998," 1997, p. 20).

The two largest parts of mandatory spending are Social Security and Medicare, which together contribute about 62 percent of total mandatory spending (CBO, "Analysis of the President's Budgetary Proposals for Fiscal Year 1988," 1997, p. 20). For 1997, federal spending for Social Security and Medicare is estimated to be over 7 percent of GDP (see Figure 1). Shortly after 2020, Medicare spending for health care is expected to exceed Social Security spending for retirement, survivors, and disability benefits. By 2030, when most baby boomers will have retired, those two programs will consume almost 14 percent of GDP (CBO, "Long-Term Budgetary Pressures and Policy Options," 1997, p. xix). Without any changes to current entitlement spending, expenditures on Social Security, Medicare, and Medicaid could consume all government revenues by 2050 and exceed them thereafter (see Figure 2).

Clearly, these trends are unsustainable. Most long-term budget projections based on current policy show the deficit mounting to around 20 percent of GDP by 2050, while the debt held by the public reaches a level somewhere between two and three times GDP (Economic Report of the President, 1997, p. 3). The short-term goal of the Administration, manifest in the 1997 balanced budget agreement with the Republican leaders in Congress, is to balance the budget by 2002, which will add a margin of safety into the budget to absorb the coming demographic burden (Elving and Taylor, 1997, pp. 1831-1836). The long-term goal is to reduce the deficit by controlling spending to avoid an explosion of debt when the baby-boomers retire (President's Budget Proposal, 1997, p. 29).

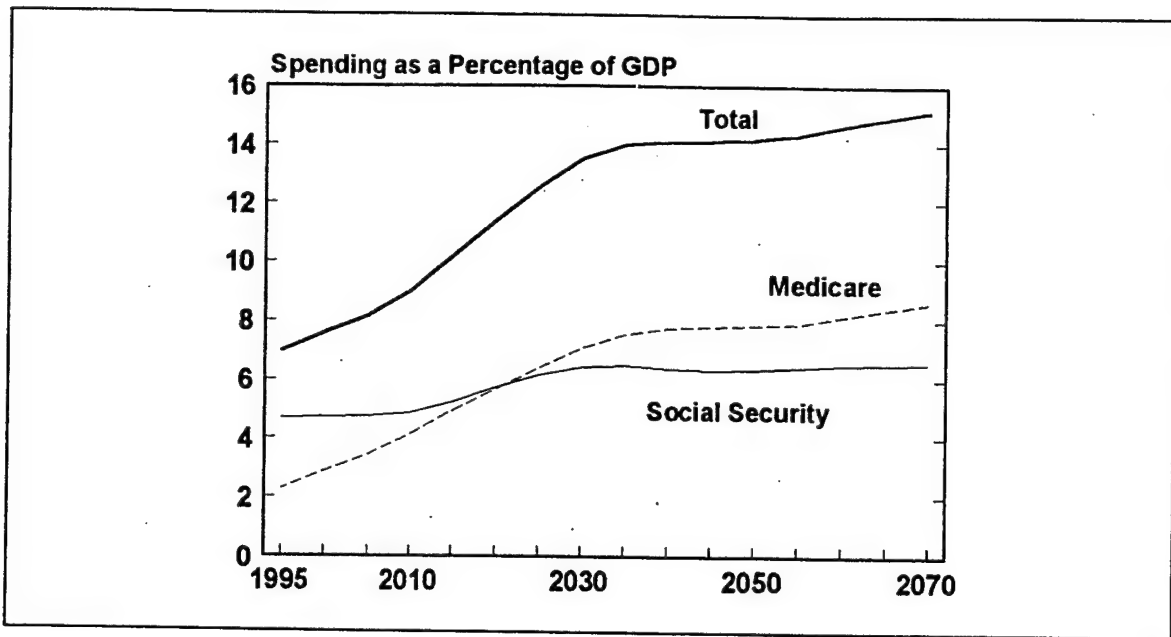


Figure 1. Projected growth in spending for Social Security and Medicare, calendar years 1995-2070. (Source: CBO, 1997, p. xix)

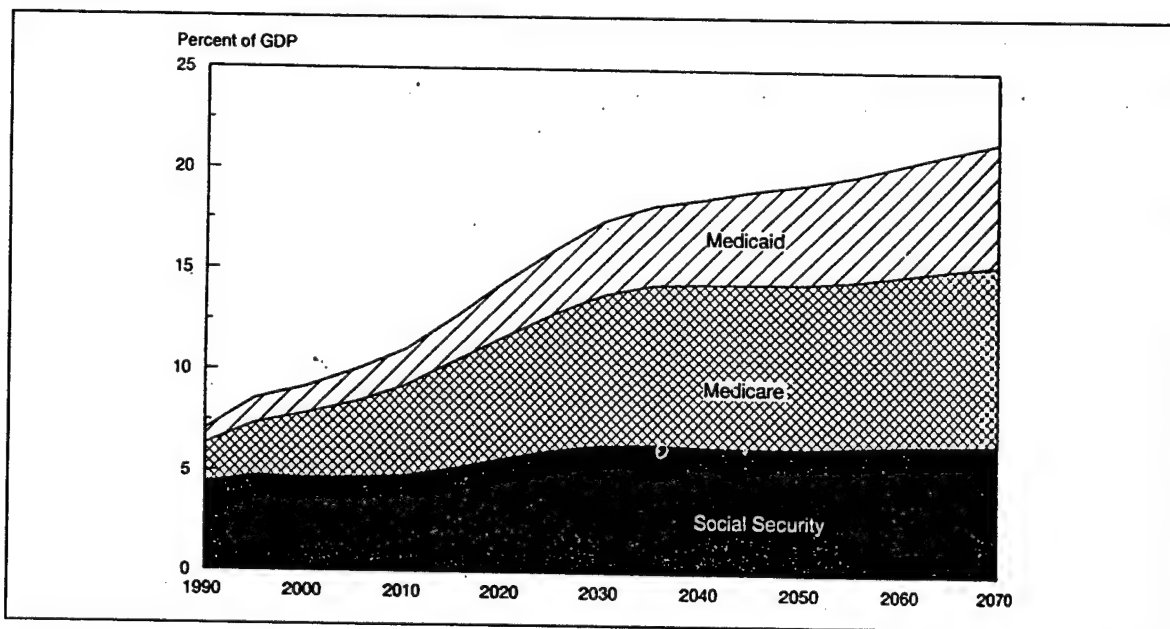


Figure 2. Projected growth in entitlement spending as a percent of GDP, calendar years 1990-2070. (Source: Economic Report of the President, 1997, p. 98)

C. ORGANIZATION OF STUDY

This thesis will generally follow a chronological progression of the genesis, evolution, and passage of the MCCA in 1988, and its eventual repeal in 1989. The legislative process and the financing mechanisms associated with the MCCA will be explored in detail. The goal is to identify the fiscal policy implications of the MCCA in its role as the first and only means-tested element of Medicare to date, and prior to 1997, as the last major addition to the Medicare program.

Chapter II will cover the beginning of MCCA with the Bowen Report and describe the major original proposals and the forces and players that gave it momentum and direction in 1986 and early 1987. This chapter highlights the changes to Medicare that the MCCA represented and explain why these changes were thought to be necessary and important in the 1980's. Chapter III focuses on the major interest groups and individuals that shaped and influenced the MCCA and the nature of their interests. Chapter IV traces the transformation and details the legislative process and political forces used to enact the MCCA. Chapter V focuses on the financing mechanisms associated with the MCCA and the implications that it had for the federal deficit. Chapter VI chronicles the elements and events that led to the repeal of the MCCA in 1989. Finally, Chapter VII will provide a summary and conclusions with an emphasis on the fiscal policy implications of the MCCA for current and future Medicare reform.

D. SCOPE OF THE THESIS

This thesis will examine the MCCA from its inception in 1986 with the Bowen Commission Report to its repeal in 1989, covering all major forms of the bill and its political allies and opponents along the way. The financing mechanisms of the bill will be examined in detail. Finally, MCCA's fiscal policy implications for current and future Medicare reform will be explored.

II. BEGINNING OF MCCA, 1984-1987

A. ENVIRONMENT

1. The Federal Economy and Deficit

In 1984, the United States economy was on a roll. GDP increased at a rate of 6.8 percent, the best in two decades (see Figure 3), while unemployment and inflation had steadily decreased from their peak in 1980 (Economic Report of the President, 1997).

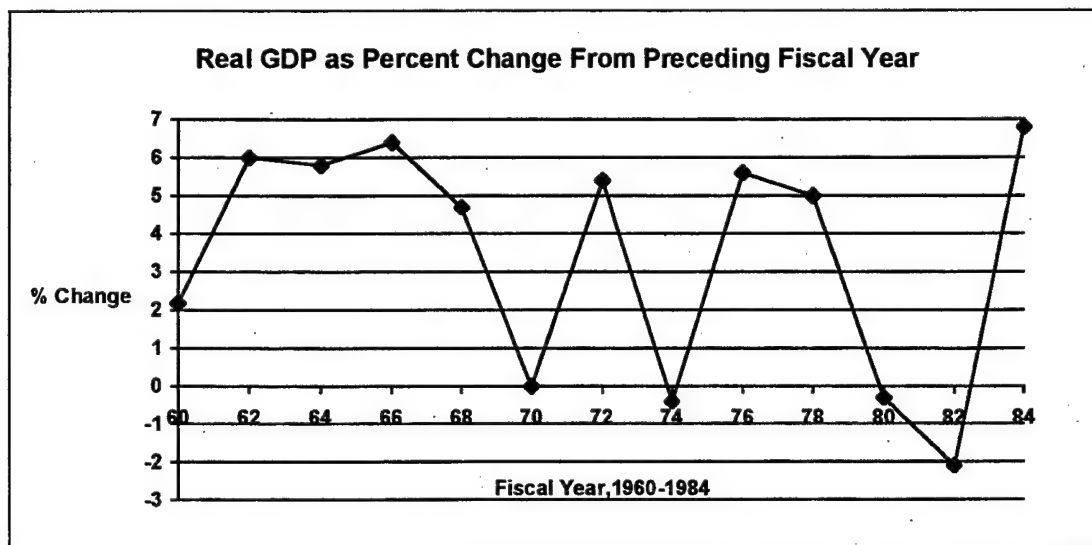


Figure 3. Real GDP as a percentage change from preceding fiscal year.
(Source: Economic Report of the President, 1997, p. 203)

“In 1984, the government reports of soaring economic growth were paralleled by booming financial optimism on the part of the American people” (The Gallup Poll, 1984). Gallup polls from July, 1984, indicate the highest levels of optimism for both the present and the future, since 1976. No significant differences were found regarding race or geographic region. However, other demographic factors such as age, education, income

and political party did show significant differences. The most optimistic respondents were young, better educated, upper income and Republican (The Gallup Poll, 1984).

In contrast to the good news of the economy and public optimism, the Reagan Administration had to face the bad news of a growing federal deficit in 1984. As a percentage of GDP, the federal budget deficit for fiscal year 1983 had increased to 6.1, the highest level since the end of World War II (see Figure 4). In dollars, it topped \$200 billion, going from \$39 to \$208 billion from 1979 to 1983 (see Figure 5), (Economic Report of the President, 1997).

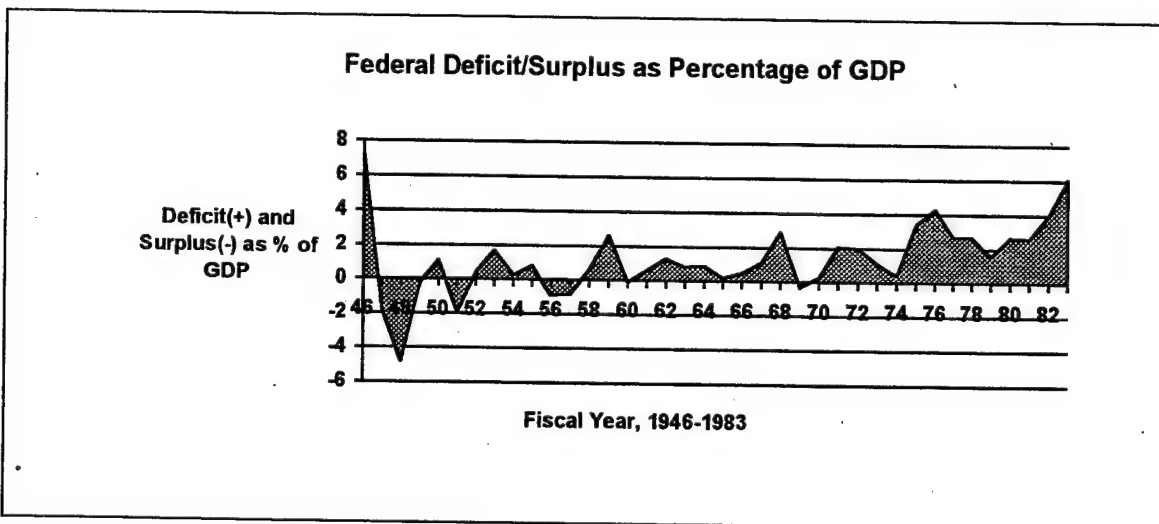


Figure 4. The federal deficit and surplus as a percentage of GDP for fiscal years 1946 to 1983. (Source: Economic Report of the President, 1997, Table B-77.)

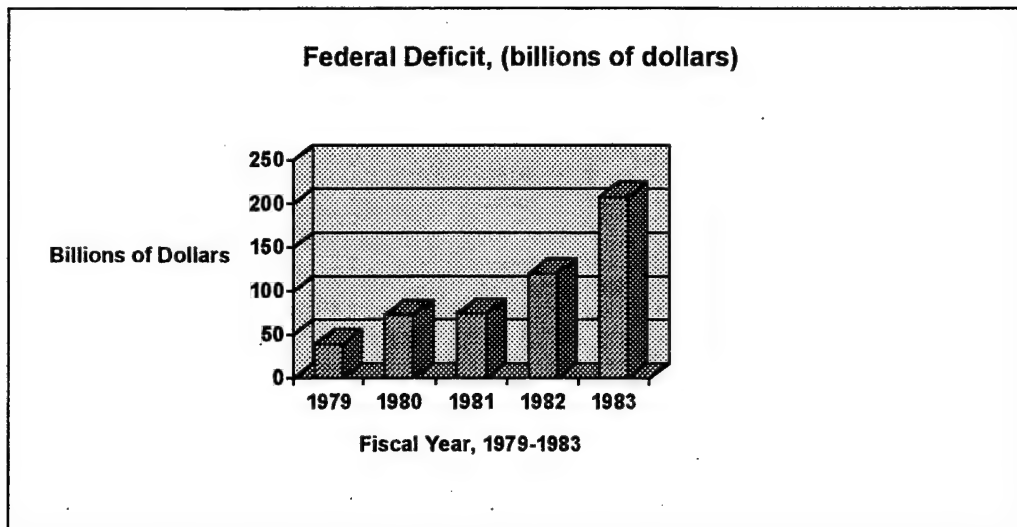


Figure 5. Federal deficit for fiscal years 1979 to 1983. (Source: Economic Report of the President, 1997, Table B-76).

In response to concerns over the growing federal budget deficit, on December 11, 1985, Congress passed the Balanced Budget and Emergency Deficit Control Act of 1985 (H J Res 372 - PL 99-177). This Act later became known as the Gramm-Rudman-Hollings Act or GRH. This Act bound Congress and the president to five years of forced deficit reductions, with the goal of balancing the budget by October 1990. "On December 12, 1985, President Reagan signed into law this radical revision of budgeting procedures, requiring that the federal deficit be eliminated using conventional legislative means or, failing that, through unprecedented automatic spending cuts" (Wehr, 1985, p. 2604).

It had an immediate effect, limiting the fiscal 1986 deficit to \$171.9 billion and \$144 billion for fiscal 1987. At the time of enactment, the fiscal 1986 deficit was projected to top \$200 billion. The actual deficit for fiscal year 1986 was \$221.2 billion (Economic

Report of the President, 1997, Table B-78), requiring cuts of \$49.3 billion according to GRH.

If the legislature failed to meet the deficit reduction goals, then the automatic cuts would take effect, divided equally between defense and non-defense discretionary accounts. Many social programs such as Social Security and Medicaid were exempt from these automatic cuts, but Medicare and four other health programs were not completely exempt. These programs were limited to 1 percent cuts in 1986 and 2 percent thereafter (Wehr, 1985, p. 2610).

2. Healthcare

By the early 1980's, there was growing concern over Medicare's rapidly rising costs and its impending bankruptcy. Medicare's costs were growing faster than the overall inflation rate. Medical costs rose 192 percent from 1970 through 1984, compared to a 157 percent rise in the Consumer Price Index. In 1984, the CBO estimated that the HI Trust Fund would be depleted by as early as 1989, or as late as 1995, depending on the economic assumptions (Wehr, 1984, p. 841). Due to Medicare's rapid growth and its sheer size as the second largest entitlement program, it had become a frequent target of Congressional cost cutting, in the deficit reduction environment that developed during the mid 1980's.

As of 1985, Medicare cuts had focused on the providers. In 1983, Congress passed the "Diagnosis Related Group" (DRG) Medicare payment system. This system authorized flat rates, by specific illness or condition, for Medicare payments to hospitals.

The intent was to pressure high-cost hospitals to be more efficient and economical (Wehr, 1984, p. 844). Also in 1983, the House Ways and Means Committee convened a two-day gathering of academic and government experts to discuss alternative financing options, such as tying beneficiaries' payments for Medicare coverage to their income levels. Congress did not embrace this suggestion of means-testing Medicare, and furthermore, had little agreement on solutions for Medicare's financing problems (Wehr, 1984, p. 841).

Further contributing to Medicare's spending imbalance and impending bankruptcy was the declining ratio of taxpayers to beneficiaries, which fell from 4-to-1 in 1965, to 3.31-to-1 in 1980, and was estimated to be 2.7-to-1 by 2015 (Wehr, 1984, p. 841). This spelled problems for the future of Medicare because it is a pay-as-you-go system. That is, current payroll taxes pay for current benefits, not future benefits.

In 1982, a Federal Advisory Council on Social Security reviewed Medicare financing, and in March 1984 issued its report. Former Indiana Governor Otis Bowen, M.D., headed this council. Some of the Advisory Council's recommendations included raising the Medicare eligibility age from 65 to 67, raising the Part A deductible and Part B premiums for beneficiaries, capping out-of-pocket costs for deductibles and coinsurance, using vouchers and "medical IRA's," and a flat rate DRG payment system for providers. It rejected means-testing, stating, "(this council) rejects any effort to tie entitlement to Medicare to a beneficiary's financial status" (Wehr, 1984, p. 842). Many of Bowen's 1984 Advisory Council recommendations, such as capping catastrophic costs, medical

vouchers, and medical IRA's, were repeated two years later in the 1986 Bowen Commission Report that he issued as the Secretary of Health and Human Services.

In 1985, the House Ways and Means Subcommittee on Health recommended several changes to Medicare, to address the deficit reduction impasse that had occurred in Congress. The only subcommittee recommendation that was rejected by the full committee was the one to require wealthier beneficiaries to pay more than the elderly poor for Part B premiums, (i.e., to means-test). Pete Stark (D-CA), Chairman of the House Ways and Means Subcommittee on Health, who proposed the means-testing initiative, said, "the financing issue would continue to be debated in the future, ... in effect, all the (full) committee did was postpone the decision" (Hook, 1986, p. 1485). The full committee accepted proposals to limit increases in payments to hospitals, a one year extension of the existing freeze on Medicare payments to doctors, and eliminated Medicare special allowances for investor-owned, for-profit hospitals. The net result was a \$10 billion cut from Medicare over 3 years, as part of a \$19 billion 3 year federal deficit reduction package (Hook, 1986, pp. 1483-1485). Although the House approved this legislation, Congress failed to enact it due to controversy concerning financing toxic waste clean-up under the "superfund" program. As a result, for the first time in 6 years, Medicare was not cut in 1985 (fiscal 1986). This increased pressure to further cut federal spending in 1986 and 1987 (Hook, 1986, pp. 115-120).

Concern was mounting that health care quality was being undermined in an ongoing effort to reduce the skyrocketing Medicare costs. Although the cuts had focused

on the providers, there was fear of a trickle-down effect on beneficiaries. The hospitals were being weaned from a cost-based formula to a DRG based system over a 3 year period, with completion by October, 1986. The doctors, on the other hand, were still on a "fee-for-service" system. The Reagan Administration wanted to shift some of the burden to the beneficiaries by making them pay more for premiums and deductibles. This would also make beneficiaries more prudent in their health care spending. This direction was in line with the 1984 Federal Advisory Council (Bowen) recommendations (Hook, 1985, pp. 115-120).

In November 1985, President Reagan nominated Otis Bowen for Secretary of the Department of Health and Human Services (HHS). In December 1985, Governor Bowen was confirmed by the Senate as HHS Secretary. Bowen, a professor of family medicine at the Indiana University School of Medicine and former two-term governor of Indiana, was widely respected as a politician and medical professional. During the confirmation hearings, he told the Senate Finance Committee, "this is one of my main priorities, to attempt to ease the burden on senior citizens in the area of acute catastrophic care," (Hook, 1985, p. 2630).

B. FEDERAL GOVERNMENT ACTION

1. Administration

In his February 4, 1986 State of the Union address, President Reagan stated, "further, after seeing how devastating illness can destroy the financial security of the family, I am directing the Secretary of Health and Human Services, Dr. Otis Bowen, to

report to me by year end with recommendations on how the private sector and government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes" (President Reagan, 1986, p. 274).

President Reagan's FY 87 Budget Proposal increased defense and foreign aid, left Social Security untouched, while cutting domestic programs such as Medicare, Medicaid, food stamps and Aid to Families with Dependent Children (AFDC). The Medicare cuts were expected to save \$4.7 billion in fiscal 1987 through new limits for hospitals' capital expenses, sharp cuts in graduate medical education, changes in current physicians' fee structures and increases in Medicare premiums and deductibles (Congressional Quarterly, 1986, p. 253).

HHS Secretary Otis Bowen took his cue from President Reagan's State of the Union address on February 4, 1986 regarding catastrophic care. He formed the Advisory Committee on Catastrophic Illness (later referred to as the Bowen Commission) to address the President's concerns. Although the President was probably referring to the cost of acute care in a hospital, Secretary Bowen indicated that he saw the long-term care issue as a key part of his commission's mandate.

Long-term care in nursing-homes made up a significant part of out-of-pocket expenses for the elderly. Medicare included a very limited nursing-home benefit, requiring beneficiaries to meet tough eligibility tests. Of the elderly who spent more than \$3,000 for

out-of-pocket medical expenses in 1985, more than 80 percent were for nursing-home stays (Rovner, 1995, p. 150).

Long-term care reform had some early support from key members of Congress, who noted that the problem was overdue for attention. Rep. Bill Gradison (R-OH), ranking member on the House Ways and Means Subcommittee on Health said, "long-term care is the largest gap in our health safety net for the elderly," (Rovner, 1986, p. 1227).

Although many in the Administration, Congress, and the private sector felt that long-term care needed increased attention, there was little consensus on how to tackle the problem. Many realized that tremendous resources would be necessary to cover the costs of long-term care. In 1986, a blue-ribbon Harvard commission predicted that long-term care services would add \$50 billion a year to Medicare's budget. Rovner notes, "The 'graying of America' is inexorably increasing the need for nursing-home and other long-term care, as more and more people survive to an age where they need help with the normal activities of daily living" (Rovner, 1986, p. 1229). In 1986, the Census Bureau estimated that between the years 1980 and 2040, the number of Americans aged 85 and older will increase at twice the rate of those aged 65-84. In 1985, 22 percent of those 85 or older were in nursing-homes, while less than two percent of those 65-74 were institutionalized (Rovner, 1986, p. 1228).

Secretary Bowen realized that long-term care costs were a significant part of out-of-pocket health care costs. The House Select Committee on Aging stated that "the burden of long-term care increased the out-of-pocket health care costs to an estimated 16

percent of the income of elderly Americans in 1986" (Rovner, 1986, p. 1228). This was the first time that out-of-pocket costs topped the 15 percent level that prompted the creation of Medicare in 1965 (Rovner, 1986, p. 1228).

Many felt that long-term care should not be covered by Medicare. Nancy Smith, of the House Select Committee on Aging, noted that, "Medicare was never designed to be a long-term care program, ... it is an acute care program, as is our health care system in general." Pete Stark (D-CA) said, "I don't see that long-term care is, ever will be, or ever should be covered by Medicare" (Rovner, 1986, p. 1228).

On November 20, 1986, the Bowen Commission Report was released. The report made recommendations for three groups: elderly who need lengthy hospitalizations; elderly who required long-term, non-hospital care; and the under-65 population at financial risk when catastrophic illness strikes. He emphasized the Commission's proposal for the first group: extending Medicare's hospital coverage and placing a \$2,000 out-of-pocket cap on part B coverage. This proposal was to be financed by adding \$4.92 monthly to the part B premium (Rovner, 1995, p. 152). The report also proposed a public education campaign to warn the elderly that Medicare, and most medigap policies, do not cover the cost of long-term care. "It also suggested encouraging individuals to open tax-preferred savings accounts for potential long-term care expenses and encouraging development of private long-term care insurance policies by offering favorable tax treatment for insurers" (Rovner, 1986, p. 2956).

The report was greeted warmly on Capitol Hill. Pete Stark (D-CA) said, "the acute care part is something I think we could agree on if the President would buy into it" (Rovner, 1986, p. 2956). Sen. Edward Kennedy (D-MA), incoming Chairman of the Labor and Human Resources Committee, called Bowen's proposals, "a major step in a new direction for the administration" (Rovner, 1986, p. 2956).

The Administration sharply criticized the Bowen report, particularly its recommendations concerning long-term care and the addition of tax incentives. A confidential memorandum from a health policy working group within the administration concluded:

there was general agreement that no further government support of long-term care expenses should be advocated. Although long-term care is a growing problem that will greatly increase in intensity over the next several decades, the problem is too complex to allow action to be taken now. There is a well known danger of opening up a new and expensive government entitlement, an action that must be avoided. States, through Medicaid and other local programs, already provide substantial resources for long-term care (Pear, 1986, p. A-1).

Furthermore, the administration was opposed to adding any new tax breaks for "medical savings accounts." They were also against giving vouchers to beneficiaries that could be used to purchase private insurance, because it "would replace a competitive private market with a Government monopoly" (Pear, 1986, p. A-1).

The Administration did not endorse the Bowen plan until February 12, 1987. The Administration was slow to make a decision due to internal differences over how to deal with this plan and possibly because they were busy with the Iran-Contra affair and waiting

for Reagan to recover from surgery. Three top officials urged Mr. Reagan to reject the Bowen plan: Attorney General Edwin Meese; James Miller, Director of the Office of Management and Budget; and Beryl Sprinkel, Chairman of the Council of Economic Advisors. President Reagan referred indirectly to the Bowen plan in his January 27, 1987 State of the Union Address, by promising to send to Congress legislation which would "free the elderly from the fear of catastrophic illness" (Rovner, 1987, p. 206). The President's proposal was identical to the Bowen plan, with the added stipulation that the program would have to pay for itself and would not add to the federal budget deficit (Pear, 1987, p. A-1).

2. Congress

Congress quickly addressed catastrophic cost legislation for two reasons: strong consensus and a Democratic majority. First, there was strong consensus from both parties that this was an important issue whose time had come. There was, however, a wide spectrum of opinion in Congress about the direction this legislation should follow. The conservative end of the spectrum was the Reagan-Bowen plan, emphasizing a cap on catastrophic costs incurred for lengthy hospital stays or extensive doctor bills. On the liberal end of the spectrum was the influential Claude Pepper (D-FL), the 86 year-old Rules Committee Chairman, and Henry Waxman (D-CA), Health and Environment Subcommittee Chairman, who saw the Bowen plan as an opportunity to expand Medicare coverage to include long-term care and an outpatient prescription drug benefit (Rovner, 1995, pp. 152-57).

The second reason, and possibly the most important, was that Congress was now under the control of the Democrats. The 1986 election had given the Senate back to the Democrats for the first time since 1980. Julie Rovner observed that "After six years of retrenchment under Reagan and the conservatives, the Democrats were eager to get back to pushing their agenda, rather than simply defending existing programs from dismantlement" (Rovner, 1995, p. 152). Ways and Means Chairman Dan Rostenkowski reflected this view in comments on the House floor during the initial debate on the catastrophic cost bill:

The President's interest in the issue and endorsement of the Bowen proposal provided Congress with the unexpected opportunity to make long overdue improvements in the Medicare Program. Improvements that, a few months earlier, virtually no one would have thought possible (Rovner, 1995, p. 152).

On January 6, 1987, the first day of the 100th Congress, Edward Kennedy, the new Chairman of the Senate Labor and Human Resources Committee, and John Melcher (D-MT), the new Chairman of the Special Aging Committee, introduced a bill (S 210) to establish a federal insurance program to protect the elderly and disabled from catastrophic medical bills. Although similar to the Bowen plan, this bill placed the new program under the Public Health Service, rather than Medicare (Rovner and Cohodas, 1987, p. 117).

On February 26, 1987, House Representatives Pete Stark (D-CA) and Bill Gradison (R-OH), the Chairman and ranking Republican, respectively, of the Ways and Means Subcommittee on Health, proposed legislation (HR 1280, HR 1281) to expand the

benefits in the Bowen plan (Rovner, 1995, p. 155). Although the bill provided longer nursing-home coverage than the Bowen plan, its novel addition was its financing. The bill tied benefit payments to income taxes, requiring the wealthier Medicare beneficiaries to pay more than those with a lower income. Stark estimated that most Medicare beneficiaries, about 65 percent, would not have paid any additional tax. This appeared politically pleasing, by adding new benefits without paying much for them (Rovner, 1995, p. 156). Although Stark's recommendation for Medicare means-testing had been shot down two years before, it seemed to increase in popularity this time.

President Reagan sent the Bowen bill to Capitol Hill on February 24. House Minority Leader Robert Michel, (R-IL), introduced the legislation (HR 1245) on February 25, and Senate Minority Leader Robert Dole, (R-KS), introduced it (S 592) on February 26, 1987, (Congressional Quarterly, 1987, p. 399).

C. SUMMARY

The fiscal and political environment that existed in the mid 1980's was central to the genesis and development of the MCCA. Two opposing forces shaped the political and legislative action during the second Reagan Administration. Optimism from a growing, vibrant economy created an atmosphere supporting increased federal spending, particularly for defense. Countering this was fiscal constraint in response to the rapidly growing federal deficit, as embodied in the Gramm-Rudman-Hollings Act of 1985. The desire to divert some of the flowing Reagan defense dollars to increased domestic spending was kept in check by attempts to balance the budget. This balance was upset

when the Democrats, who regained control of Congress in 1986, saw a green light for increased domestic spending. Additionally, Reagan's appointment of Otis Bowen as the new HHS Secretary in 1985 was key to the momentum that the MCCA created. Highly respected, motivated, and aggressive, Secretary Bowen released the Bowen Commission Report in 1986, receiving widespread approval from Congress. The Reagan Administration reluctantly endorsed the Bowen report over two months later, with the stipulation that any additions to the Medicare program would have to be budget neutral. The catastrophic coverage bill had broad support from both parties, but there was a strong push from some liberal Democrats for more extensive Medicare reform.

The next chapter focuses on the major interest groups and individuals that shaped and influenced the MCCA and the nature of their interests.

III. MAJOR INTEREST GROUPS OF MCCA

A. STRUCTURE

The structural model that best describes the relationship between the major interest groups for the MCCA is a set of four concentric circles, representing Congress, the Administration, lobby groups, and the public (see Figure 6).

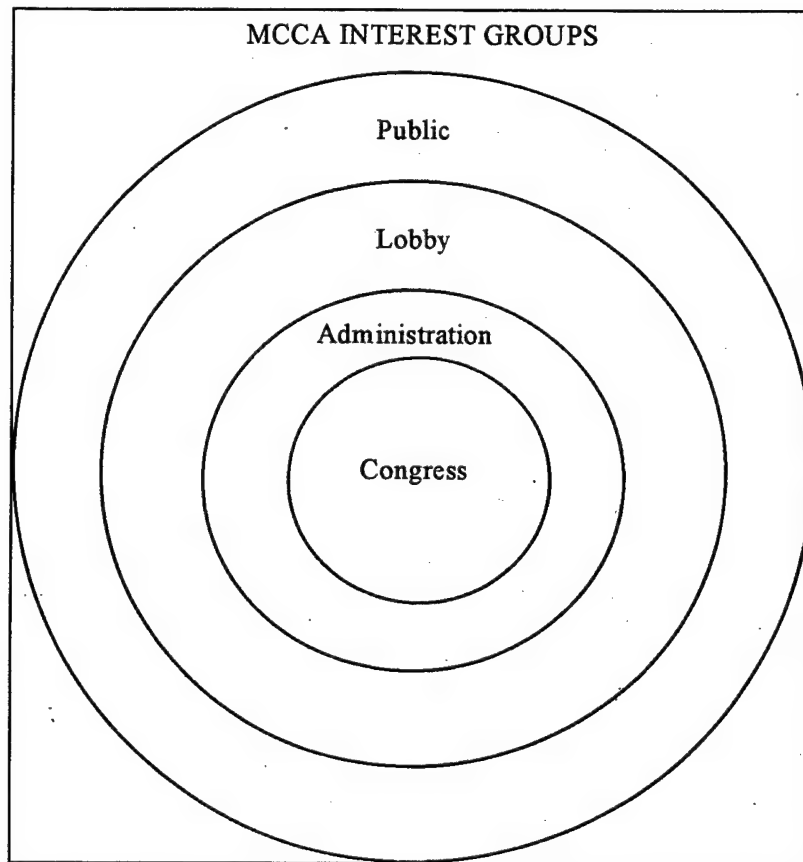


Figure 6. MCCA interest groups.

In the center of the structure is Congress, where the legislation originates. The Administration occupies the next circle, having the most direct access to Congress and arguably the most influence. Next, are the lobby groups who have less direct or formal access but possibly as much influence as the administration. Last, the public is on the outer layer, the furthest removed from Congress and with little direct access, but with considerable influence on Congress, especially during election years.

The first two groups, Congress and the administration, that make up the inner part of the network were the primary forces responsible for creating and passing the MCCA. The outer two, the lobby groups and the public, had the strongest influence on the repeal of the MCCA.

There were many individuals and groups that influenced the MCCA's outcome. The intent of this chapter is to highlight the primary actors and briefly describe their purpose.

B. CONGRESS

1. House of Representatives

Two committees in the House have jurisdiction over Medicare: Ways and Means and Energy and Commerce (renamed in 1995 the Commerce Committee). The Ways and Means Committee has sole jurisdiction over Part A and the Energy and Commerce Committee has jurisdiction over Part B of Medicare (Evans, 1995, pp. 34-36).

In 1988, the Chairman and ranking member, respectively, of these two committees were: Representatives Dan Rostenkowski (D-IL) and Bill Archer (R-TX) for Ways and

Means, and Representatives John Dingell (D-MI) and Robert Michel (R-IL) for Energy and Commerce.

a. Representative Dan Rostenkowski (D-IL)

As Chairman of the powerful Ways and Means Committee, Dan Rostenkowski was a strong proponent and a key player of the MCCA from the beginning to the end. He played two prominent roles, one in the passage and another in the repeal of the MCCA. First, with the assistance of John Dingell (D-MI), he successfully prevented Claude Pepper from adding long-term care benefits to the MCCA. Second, by becoming the main actor in a true anecdotal story that is commonly used in references to the describe the MCCA and the emotion that it evoked in the elderly beneficiaries. During the congressional break in August 1989, Dan Rostenkowski spoke at a town meeting with a number of senior citizens in his district. He explained the added benefits of the MCCA. As he was leaving, a crowd of angry senior citizens against the MCCA blocked his car's departure. In full view of CNN cameras, was an elderly woman pounding on the hood of his car, forcing him to escape from the angry mob on foot (Moon, 1996, p. 126). This incident marked a major turning point that led to the repeal of the MCCA in November 1989 and has become an identifying trademark of the MCCA.

b. Representatives Pete Stark (D-CA) and Bill Gradison (R-OH)

These two were the Chairman and the ranking member, respectively, of the Ways and Means subcommittee on Health. They had the most influence on the shaping

and the eventual form and content of the MCCA that passed in 1988. Their two original bills (HR 2180/2181), introduced in January 1987, later became HR 2470, the bill that became the MCCA in July 1988 (Rovner, 1988, pp. 1604-1611).

c. Representative Claude Pepper (D-FL)

Congressman Pepper was the Chairman of the Rules Committee. Although this committee had no jurisdiction over the MCCA, he was the driving force in Congress to transform the MCCA into a vehicle for expanding Medicare (Rovner, 1987, p.1591). At 87 years old, and with over 40 years in Congress, he was an extremely influential and powerful force on both sides of the aisle. A long time advocate of senior citizens, he pushed hard to include both long-term care (HR 65, 3436, and 2762) and prescription drug benefits (HR 2761) within MCCA (Rovner, 1988, pp. 1491-1493).

d. Representative Henry Waxman (D-CA)

As Chairman of the Energy and Commerce Subcommittee on Health and the Environment, he was the major proponent for including the prescription drug benefit within the MCCA. He worked closely with Claude Pepper on both the long-term care and the drug benefit aspects of the MCCA (Rovner, 1987, pp. 1263-64).

e. Representative Edward Madigan (R-IL)

As the ranking member on the Energy and Commerce Subcommittee on Health and the Environment, he balanced Henry Waxman and the subcommittee, often objecting to adding any new benefits to Medicare (Rovner, 1987, pp. 1263-64).

2. Senate

The Finance Committee has primary jurisdiction over Medicare in the Senate. The Labor and Human Resources Committee is involved in health issues, but its health jurisdiction is narrower than that of the Finance Committee (Evans, 1995, pp. 39-40).

a. Senator Lloyd Bentsen (D-TX)

As the Chairman of the Finance Committee and a longtime health care advocate, he was instrumental in shaping the MCCA. His bill (S 1127), was the primary Senate vehicle for the MCCA, eventually being merged with the House version (HR 2470) to become the MCCA (Rovner, 1987, pp. 1136-37).

b. Senators George Mitchell (D-ME) and John Heinz (R-PA)

As Chairman of the Finance Subcommittee on Health and ranking member on the Special Aging Committee, they were responsible for several bills and amendments relating to the MCCA, most notably, the drug amendment to the Bentsen bill (S 1127) (Rovner, 1987, p. 2128).

c. Senator Edward Kennedy (D-MA)

As the Chairman of the Labor and Human Resources Committee, Senator Kennedy introduced the first catastrophic costs bill in the Senate in 1987 (S 210). He was also involved with the MCCA from beginning to end (Rovner, 1987, p.117).

d. Senators David Pryor (D-AR) and Dave Durenberger (R-MN)

As Chairman of the Special Aging Committee and ranking member of the Subcommittee on Health, Senator Pryor and Senator Durenberger played key roles in passing and repealing the MCCA (Rovner, 1987, pp. 2677-79).

C. ADMINISTRATION

The primary arm of the administration responsible for the Medicare program is the Department of Health and Human Services (HHS), chaired by Dr. Otis Bowen. Except for Secretary Bowen, the Administration maintained a low profile throughout MCCA enactment and repeal. There were two presidents involved with the MCCA, Reagan who signed it and Bush who repealed it. President Reagan played a role in the enactment by his endorsement of the Bowen plan, despite the objections of his senior aides. President Bush, on the other hand, did not provide much support to save the MCCA from repeal.

1. Secretary Otis Bowen

He was the primary person responsible for getting the MCCA started. An accomplished medical and political professional, he was uniquely qualified to address the catastrophic health care cost issue. Bowen had chaired the 1984 Social Security Advisory Council that recommended several changes to the Medicare program including a cap on catastrophic Medicare costs. Without his enthusiasm and determination, his 1988 Bowen Commission Report would have never gained the tremendous favor and momentum that it enjoyed in the 100th Congress in early 1987. Sensitive to the limitations of the Medicare program, particularly long-term care, Bowen advocated closing the gaps in acute care for

Medicare beneficiaries. Recognizing the costs and risks of over-expanding the Medicare program, he proposed a simple, budget neutral plan that would cap out-of-pocket costs for all beneficiaries across-the-board. Throughout the MCCA process, he fought to keep the bill close to its original intent, capping catastrophic costs, and opposed attempts to use it as a vehicle for expansion of other Medicare benefits (Moon, 1996, p. 110).

2. President Ronald Reagan

President Reagan triggered the process which ultimately produced the MCCA through two actions. First, he selected Bowen as his HHS Secretary; he then charged Bowen to study the problems associated with catastrophic health expenses in his 1986 State of the Union Address. However, that too, may have been Bowen's idea, as Julie Rovner states:

Ronald Reagan had lost significant standing among elderly people with his proposed Social Security cuts in his controversial 1981 budget - an unpopular move the Democrats capitalized on in the 1982 elections. In 1985 administration officials were therefore looking to mend some fences even as they were seeking new domestic initiatives. The specific idea (capping catastrophic medical costs) came at the instigation of Otis R. Bowen (Rovner, 1995, p. 151).

3. Health Care Financing Administration (HCFA)

HCFA was created by the Secretary of Health and Human Services on March 9, 1977, and is a major subdivision of the HHS Department. HCFA consolidated responsibility in one agency for administering the largest federal health programs, Medicare and Medicaid. HCFA "has approximately 4,000 employees engaged in policy

development, program operations, legislative analysis and liaison activities, health care research and demonstrations, budget preparation and analysis, actuarial studies, data collection and processing, enforcement of health care quality standards, and public information activities” (HCFA, 1997, HCFA Internet Home Page).

The main role that HCFA played in the MCCA process was to estimate the cost of proposed Medicare changes and recommend the premium increases necessary to cover those costs. The HCFA often worked in concert with the Office of Management and Budget (OMB) to estimate costs and actuarial values (Rovner, 1987, p. 2243).

D. LOBBY GROUPS

The MCCA lobby groups represent a heterogeneous mix of interest groups. Three categories can be identified: beneficiary representative, health care professional representative, and the “for-profit” health industry representative, mostly insurance and drug companies. Of particular note is that most of these groups were against the MCCA, the important exception being the American Association of Retired Persons and the National Council for Senior Citizens. The following lobby groups are only a fraction of the total number of interest groups active on health care issues, but they are the principal groups involved in the enactment and repeal of the MCCA.

1. American Association of Retired Persons (AARP)

The 25 million-member AARP was one of the MCCA’s leading backers. They estimated that about one-quarter of Medicare beneficiaries would benefit annually from expanding the program. However they were frustrated that the bill did not further address

medical expenses, especially the cost of long-term care (Rovner, 1987, p. 1638). They did however, support the MCCA from enactment to repeal.

2. National Council of Senior Citizens (NCSC)

The NCSC also strongly backed the MCCA (Rovner, 1988, p. 780); but they too complained that the bill did not address long-term care (Rovner, 1988, p. 1491).

3. National Committee to Preserve Social Security and Medicare (Roosevelt Group)

This group was formed in 1982 by former Representative James Roosevelt (D-CA) (1955-1965), son of President Franklin D. Roosevelt. By 1984, they had raised over \$5 million, through direct mailings and television membership drives including a spot with three prominent members of Congress (Representatives Claude Pepper (D-FL) and Andrew Jacobs (D-IN), and Senator Mark Hatfield (R-OR)) and actor Lorne Greene. The television spot warned viewers to take "immediate action" to save Social Security and Medicare benefits. The Roosevelt group was criticized for its "hard-sell" tactics as early as 1984, as illustrated by a statement given on the House floor by J.J. Pickle, (D-TX), Chairman of the House Ways and Means subcommittee on Social Security: "It is irresponsible to use scare tactics to arouse concern and mobilize the public to defend our Social Security system against a false threat," (Fessler, 1984, pp. 1310-1313). The group's tactics and controversy continued into 1988, resulting in Congressional hearings charging that the group's tactics were "misleading" and "inflammatory" (Murphy, 1988, pp. 778-779). This group opposed the MCCA from the outset because of its financing and lack of long-term care coverage. They gained popularity throughout the MCCA process,

and probably had the most significant impact of any lobby group leading to the repeal of the MCCA (Rovner, 1989, p. 86).

4. Villers Advocacy Association (Families USA)

The Villers Advocacy Association (changed to Families USA in 1989), is a non-profit advocacy for low-income senior citizens (Rovner, 1989, p. 2317). This group focused on the elderly poor and was particularly active on the long-term care issue. They worked very closely with Claude Pepper (D-FL) for long-term care legislation (Rovner, 1989, pp. 524-25). They criticized the MCCA for its lack of long-term care benefits.

5. Seniors Coalition Against the Catastrophic Act (SCACA)

Daniel Hawley, the founder and president of this grass roots group from Las Vegas, Nevada, testified before the Senate Finance Committee during June 1989 MCCA hearings. He claimed to have 346,427 signatures on a petition demanding the repeal of the MCCA. Committee Chairman Lloyd Bentsen took exception to Hawley's comments regarding the future political downfall of any member of Congress who voted for MCCA. According to one committee staffer, "Bentsen had the same look on his face he did at the 1988 vice presidential candidate debate just before he tore into Dan Quayle for comparing himself to the late President John F. Kennedy," (Rovner 1989, p. 1330). The SCACA was one of the largest of the several grass-roots groups that sprang up against the MCCA.

6. National Association of Retired Federal Employees (NARFE)

This group represented 750,000 federal retirees who already had catastrophic coverage benefits that were equal to or better than those proposed under MCCA (Rovner,

1987, p. 2463). They represented higher income beneficiaries that would have to pay additional premiums under the MCCA for benefits that they already had. The NARFE and the Retired Officers Association (ROA) joined forces with the Roosevelt group to lobby against the MCCA (Rovner, 1989, p. 86).

7. American Medical Association (AMA)

The AMA was one of Washington's most influential power brokers with over 250,000 members in 1984. They opposed Medicare from its inception in 1965, and were also against the MCCA (Pressman, 1984, pp. 15-19). The AMA lobbying role against the MCCA was relatively subtle, compared to some of the aforementioned groups.

8. Pharmaceutical Manufacturer's Association (PMA)

This group lobbied very hard against prescription drug benefits in the MCCA because they feared price controls would follow. In the summer of 1987, they spent an estimated \$3 million in one mass mailing to prevent the Senate from adopting a drug provision in the bill; the House had just adopted such a measure. They later negotiated with the Senate and endorsed their version, but lobbied against the House version with direct mailings to the constituents of the Ways and Means Subcommittee on Health. Pete Stark (D-CA), said the PMA was involved in "one of the sleaziest lobbying campaign's I've seen in some time" (Rovner, 1988, p. 780).

9. Health Insurance Association of America (HIAA)

The HIAA is a major lobbying organization for 270 health insurance companies (Lieberman, 1993, p. 37). The HIAA was against the MCCA because it feared health

insurance price controls in response to anticipated health care cost increases (Rovner, 1989, p. 2463).

E. PUBLIC

In 1984, 74 percent of the public favored increased spending for Medicare (Gallup Poll, 1984, p.243). When asked in 1986 and 1987, what parts of the budget should be cut in order to reduce the federal deficit, 88 percent disapproved of cutting Medicare or Social Security (Gallup Poll, 1986, p. 45 and 1987, p. 199). In 1989, 83 percent of the public said that they opposed lowering Medicare payments to providers to lower the federal deficit. Further, the Gallup Poll noted: "Any attempt to impose increased taxes or a means-test on affluent Social Security recipients or to limit Medicare benefits would run into a solid wall of opposition, although even modest cuts in these programs - the largest in the domestic budget - would make a big dent in the federal deficit" (Gallup Poll, 1989, p. 105). Proposals to trim Social Security and Medicare elicit greater public opposition than any other deficit reduction measures studied (Gallup Poll, 1989, p. 104-105).

F. SUMMARY

This chapter highlights the major players involved in the MCCA process, notably the Congress and the Administration who largely supported the bill, and the lobby groups, who were active in its repeal. Many of these participants will be discussed in further detail in the following chapters.

The next chapter describes the transformation of the original Bowen plan and the legislative process that led to the enactment of the MCCA in 1988.

IV. LEGISLATIVE PROCESS AND PASSAGE OF THE MCCA, 1987-1988

A. BACKGROUND

1. Bowen Commission Report

The Bowen Commission Report was released on November 20, 1986 by the Secretary of Health and Human Services, Dr. Otis Bowen. The report was widely accepted by both houses of Congress and was the seed that started the legislative process resulting in the enactment of the MCCA on July 1, 1988.

Although the report broadly addressed the health care needs of three beneficiary groups, the emphasis of the report was on capping the costs for those requiring a lengthy hospital stay. That is, the Bowen report focused on the need to cap the catastrophic costs incurred through acute vice long-term care.

To address the long-term care issue, the report recommended a public education campaign that emphasized that Medicare and most medigap policies lacked long-term care benefits. The report also recommended that the federal government authorize tax preferred savings accounts for long-term care expenses.

2. Bowen Plan

The Bowen plan embodied the essential elements of the Bowen report that Secretary Bowen felt were achievable goals for legislation and would also satisfy President Reagan's mandate to "address the problems of affordable insurance...when catastrophic illness strikes" (Reagan, 1986, p. 274).

The Bowen plan was simple in design, limited in scope, and budget neutral. It primarily sought to cap the out-of-pocket costs for those over 65 who required lengthy hospital stays. It proposed to extend Medicare's hospital coverage and put a \$2,000 out-of-pocket cap on the Part B coverage by adding \$4.92 monthly to the Part B premium. The premium increase was designed to be budget neutral by fully funding the costs from the beneficiaries vice from the federal government general fund.

There was concern in Congress about the other two groups addressed in the Bowen report but largely omitted in the Bowen plan. The omitted groups were those over 65 requiring long-term care outside the hospital and the under 65 group who have excessive out-of-pocket health care costs. The population estimates in 1987 of these two groups not included in the Bowen plan were 1.4 million for those requiring long-term (nursing home) care and 2.8 million for those under 65 who face out-of-pocket medical expenses in excess of \$5,000 per year. By comparison, the estimated size of the group included in the Bowen plan, those requiring coverage for extensive hospital stays, was approximately 1.4 million people. (Rovner, 1987, pp. 206-08)

The general consensus in 1987, both in the administration and Congress was that focusing on this one group, that is, those over 65 requiring help covering costs for lengthy hospital stays, was the best way to ensure passage through Congress. The outpatient long-term care issue was generally viewed as too expensive, too complex, and too difficult to get through Congress at this time.

3. Reagan/Bowen Bills

The starting point in Congress for the MCCA was the Reagan/Bowen bills introduced in the House and the Senate on February 25 and 26, 1987 as HR 1245 and S 492, respectively. The bills were identical to the Bowen plan, providing beneficiaries coverage for up to one year of hospital care and limiting their annual out-of-pocket expenses for Medicare-covered services to \$2,000. The increased benefits would be financed by an increase of \$4.92 to the \$17.90 monthly Part B premium. These bills provided additional coverage past the current 150 day hospital stay limit and a cap on out-of-pocket costs which did not exist under current law. Health-related costs that were not covered under the Bowen plan included long-term nursing-home care, outpatient prescription drugs, dental care, and eye care. (Rovner, 1987, p. 297)

4. Means-Tested Benefits

The term means-tested is used throughout this thesis to describe the supplemental premium that was introduced in the Stark-Gradison bills and was also part of the MCCA. Two prominent healthcare authors (Moon and Rovner) also referred to the supplemental premium in the MCCA as means-tested. The use of the term means-tested in this thesis and other references to the MCCA is a wider interpretation of the term than the strict, traditional usage. The definition of means-test in The McGraw-Hill Dictionary of Modern Economics is "the requirement that applicants for public assistance must prove their need before they become eligible to receive benefits" (Greenwald, 1983, p. 293). In The MIT Dictionary of Modern Economics means-tested benefits are defined as "Benefits that may

only be paid if the claimant's income is less than a certain value" (Pearce, 1986, p. 270). The Department of Health and Human Services (HHS) states that a program is "'means-tested' if eligibility for the program's benefits, or the amount of such benefits, or both, are determined on the basis of income or resources of the eligibility unit seeking the benefit" (Federal Register Online via GPO access, Internet).

In contrast, the additional benefits of the MCCA were available to all Medicare enrollees, regardless of their income. The supplemental premium in the MCCA is referred to as "means-tested" in this thesis because it charged the majority (63 percent) of the costs of the MCCA to upper income beneficiaries. The upper-income enrollees had to pay both the supplemental and the flat premium, whereas, the lower and middle income enrollees only had to pay the flat premium for the MCCA. The MCCA supplemental premium will be referred to as "means-tested" throughout this thesis to maintain consistency with the primary references used herein.

B. TRANSFORMATION OF THE MCCA

1. House

Prior to the introduction of the Bowen plan in the form of the Reagan/Bowen bills on February 25 and 26, 1987, both the House and the Senate had been holding hearings in several subcommittees on the catastrophic health care cost issue for over a month. The House immediately introduced legislation on catastrophic health care costs with the Stark-Gradison bills.

a. Stark-Gradison Bills (HR 2180/81)

Representatives Pete Stark (D-CA) and Bill Gradison (R-OH), Chairman and ranking member, respectively, of the Ways and Means Health Subcommittee, introduced legislation on February 26, 1987, intended as an alternative to the Bowen bill. Stark commented, "we believe Secretary Bowen's proposal is a very good first step, but it can be made better" (Congressional Quarterly, 1987, p. 399). Like the Bowen bill, the Stark-Gradison bills (HR 2180 and 2181) would expand Medicare to cover long hospital stays, but not long-term care outside the hospital. Both plans would also limit the amount that beneficiaries would have to pay for Medicare-covered services. The Stark-Gradison bills would cap the amount beneficiaries must pay for covered hospital and doctor costs at \$1,700 per year vice \$2,000 per year in the Bowen bill.

The key difference between the two proposals was the financing: the Stark-Gradison bills were means-tested and the Bowen bill was not. The Stark-Gradison bills would pay for these new benefits, estimated to cost \$10.4 billion between 1988 and 1990, by taxing upper income Medicare beneficiaries the value of the portion of Medicare benefits now financed by the government. This additional tax targeted only the upper income or approximately one third of all Medicare beneficiaries. Such a tax would raise \$11.3 billion in those same three years. It was estimated that in 1988 those in the 15 percent tax bracket would pay an additional \$265 in income taxes, and those in the 28 percent bracket would pay \$495 more in taxes. Additionally, over 65 percent of the elderly

would not have to pay any additional tax because their income would be too low. (Rovner, 1987, p.434)

The Stark-Gradison bills became the foundation upon which the MCCA was built. On April 19, 1987, after two days of closed door deliberations, the House Ways and Means Health Subcommittee approved this legislation by a 9-2 vote. The financing mechanism, however, was more controversial, splitting the panel 6-5. They rejected the more modest Bowen bill (HR 1245) by a 3-8 vote. This action opened the way for full committee approval by May, and floor action by June, 1997.

The subcommittee made some changes to the benefits and the financing of the original Stark-Gradison bills. The maximum amount that beneficiaries would have to pay for Medicare-covered outpatient care by physicians was reduced from \$1,700 to \$1,000 per year. The bill also extended Medicare coverage in a skilled-nursing facility from the current 100 days to 150 days, health services at home from one to six weeks, hospice benefits past 210 days for terminally ill patients, and raised the mental health reimbursement limit from \$250 to \$1,000 per year. To pay for the added benefits, the monthly Part B premium would be raised \$5.40, from \$17.90 to \$23.30. The means-tested part of the financing remained the same as the original Stark-Gradison bills (HR 2180 and 2181). (Calmes, 1987, p. 686)

The House Ways and Means Committee approved the Stark-Gradison bills (HR 1280 and 1281) on May 7, 1997. The full committee markup of the Health Subcommittee bills left the benefits unchanged but again the financing was adjusted. Under

the previous subcommittee plan, the benefits would have been financed by making the upper income beneficiaries pay additional income tax on the subsidized part of Medicare coverage. That plan was abandoned in favor of a two-tiered Medicare premium. The Part B monthly premium would be raised by \$1.00 per month for all beneficiaries and a new annual "supplemental premium" would be paid by only upper income beneficiaries that would increase with the beneficiaries' income (Rovner, 1987, pp. 915-18).

On May 19, 1997 the House Ways and Means Committee formally approved HR 2470, merging HR 1280 and 1281 (the Stark-Gradison bills) into one bill. HR 2470 was a combined but otherwise unchanged version of the two-bill package approved by full committee. It then went to the Energy and Commerce Committee, which shared jurisdiction over a portion of Medicare (Rovner, 1987, p. 1082).

b. *Waxman-Madigan Bill (HR 2485)*

Representatives Henry Waxman (D-CA) and Edward Madigan (R-IL), Chairman and ranking member, respectively, of the Energy and Commerce Health Subcommittee introduced their plan for outpatient prescription drug coverage on May 20, 1987. Under their proposal, HR 2485, 100 percent of the cost of prescription drugs would be covered after the beneficiary paid a \$400 annual deductible. The Health and Environment Subcommittee added the prescription drug benefit to HR 2470 on June 9, 1987, by a 9-1 vote (Rovner, 1987, pp. 1263-64).

Although this addition had been a longtime goal of Waxman's, its inclusion came about at the urging of House Speaker Jim Wright (D-TX), in an effort to pacify the

powerful Claude Pepper who had been pushing for inclusion of a drug benefit. Additionally, Speaker Wright pushed for inclusion of the drug benefit because he wanted a "Democratic stamp" on the catastrophic care plan that began as a Reagan initiative. (Rovner, 1995, p. 157)

Although there were similarities between Stark's and Waxman's Health Subcommittees, with both headed by a California liberal Democrat and a midwestern Republican moderate, there were some significant differences. Congressman Waxman was the "House's consummate liberal health expert," and the full committee Chairman, John Dingell (D-MI), also a liberal, gave Waxman full rein in pushing a liberal Democrat agenda. Rovner observed, "His (Waxman's) tack was to bridge the gap between Pepper's desire to expand Medicare as much as possible and Stark's wish to produce a bill that President Reagan would sign" (Rovner, 1995, p. 157).

The full Energy and Commerce Committee approved its version of HR 2470 (adding the prescription drug benefit) on June 17, 1987 by a vote of 30-12. The Energy and Commerce drug benefit provision would pay the full cost of outpatient prescription drugs after a \$500 annual deductible is met. The day before, on June 16, the Ways and Means Health Subcommittee added its own version of the drug benefit to HR 2470, on a 7-4 party-line vote. The Ways and Means version would cover 80 percent of the costs of outpatient drugs after a beneficiary has paid an \$800 deductible. The full Ways and Means Committee approved the addition of the prescription drug benefit (same

as subcommittee version) to HR 2470 on June 24, 1987, by a party-line vote of 24-12.

(Rovner, 1987, pp. 1327-28)

The Reagan Administration was unhappy with both committees about the direction that HR 2470 was taking. They were concerned that the House was attempting to expand Medicare benefits beyond the original intent of the Bowen plan and that the costs were too large. Secretary Bowen wrote a letter to both committees on June 15, stating "should this legislation reach the President's desk in this form, other senior advisors and I would be forced to recommend a veto" (Rovner, 1987, p.1327).

At this point in the development of the MCCA, many of the Republican members of the two House subcommittees on health were critical of the cost and the financing of the additional benefits to HR 2470. Additionally, there were wide gaps between the cost estimates for the program coming from the Congressional Budget Office (CBO) and the Department of Health and Human Services (HHS), with the CBO costs usually far below those of the HHS. Representative Bill Gradison insisted "we don't have enough facts right now to make an intelligent decision - when the estimates are so far apart a lot of warning lights go off" (Rovner, 1987, p. 1328).

c. Pepper Bills (HR 2761 and 2762)

Chairman Claude Pepper (D-FL) of the House Rules Committee, announced at a news conference on June 24, 1987 that he would ask the other Rules Committee members to allow consideration of his bills, HR 2761 (prescription drug benefit) and HR 2762 (long-term home care) as amendments during floor consideration of

HR 2470. His drug benefit was far more generous than were the proposals from the other House committees. His bill (HR 2761), would cover all outpatient prescription drug costs after payment of a \$250 annual deductible. By comparison, the Energy and Commerce version had a \$500 deductible and the Ways and Means version would only cover 80 percent of costs after an \$800 deductible (Rovner, 1987, p. 1380). The long-term home care bill (HR 2762), would establish a new benefit for anyone of any age who was certified by a physician to need assistance with two or more of the recognized "activities of daily living" (bathing, eating, dressing, etc.) to receive long-term care at home. Congressman Pepper used these bills as a means to broaden the scope of the MCCA (HR 2470) (Rovner, 1987, p. 1381).

Pepper won an important concession on the long-term issue from House Speaker Jim Wright during a "summit" luncheon on July 9, 1987. Pepper agreed to back off from his demand on a floor vote to add his long-term care bill as an amendment to HR 2470. In exchange, Speaker Wright promised that the full House would vote on his proposal at a future date and on another vehicle. (Rovner, 1987, p.1591)

d. House Approval of HR 2470

By the end of June 1987, the House needed some time to catch its breath and examine the benefits and costs that been added to the "fast track" catastrophic health care cost bill, HR 2470. House Speaker Jim Wright called an informal meeting among key members of the Ways and Means, and Energy and Commerce Committees on June 30, 1987, to resolve differences between the two versions of HR 2470 from their respective

Health subcommittees. The result of the meeting was to pare back many of the benefits in the bill (Rovner, 1987, p. 1437).

Under the compromise, Medicare would only pay 80 percent of the cost of outpatient prescription drugs (per the Ways and Means version) and the annual deductible was set at \$500 (per the Energy and Commerce version). Provisions encouraging the use of generic-drug substitutes were put back in after the drug industry had pressured the Energy and Commerce Committee to remove it. The bill would pay for unlimited hospital stays after an annual deductible of \$520 and would limit annual Part B costs to \$1,000. It also kept the home health and respite care but cut the mental health provision.

The rank and file of the two committees were upset when they were informed of the changes to the bill on the following day, especially the deletion of the mental health provision. On July 1, House leadership decided to postpone floor action on the bill from the scheduled date of July 9 to the week of July 20, 1987. In addition to concerns that the bill was moving too fast, and disagreement over which benefits to add and their costs, there was also the influence of Rules Committee Chairman Claude Pepper, who was pushing for a much broader Medicare package, and was a major factor for the delay. (Rovner, 1987, pp. 1437-38)

During the week of July 13, 1987, the House approved HR 2941, a compromise bill combining provisions from the two committee versions of HR 2470 (from the Ways and Means and Energy and Commerce Committees). This bill contained the same benefits as the leadership agreed upon July 1, but added back the mental health

benefit. The financing was still unchanged at an additional \$5 per month to the Part B premium and a means-tested "supplemental premium" (Rovner, 1987, pp. 1590-93).

On July 22, 1987, the House approved its version of the MCCA, HR 2470 by a vote of 302-127. 61 Republicans voted for it and 14 Democrats voted against it. As approved by the House, HR 2470 contains the text of HR 2941. The main provision would be to limit out-of-pocket costs that beneficiaries would pay for Medicare-covered services. Under HR 2470, they would have to pay \$580 for hospital stays, \$1,043 for physician and outpatient charges, and \$175 for skilled-nursing-home care, for a total of \$1,798 per year for out-of-pocket costs. The outpatient prescription drug benefit covered 80 percent of the costs after a beneficiary met a \$500 annual deductible. The bill did not contain coverage for long-term, preventative health, dental, eye or foot care. The financing changed slightly, with a \$1 Part B monthly premium increase for all beneficiaries and a means-tested annual supplemental premium that would range from zero for beneficiaries with annual income below \$6,000 to a maximum premium of \$580 for those with incomes over \$14,166 (see Figure 7). (Rovner, 1987, 1637-39)

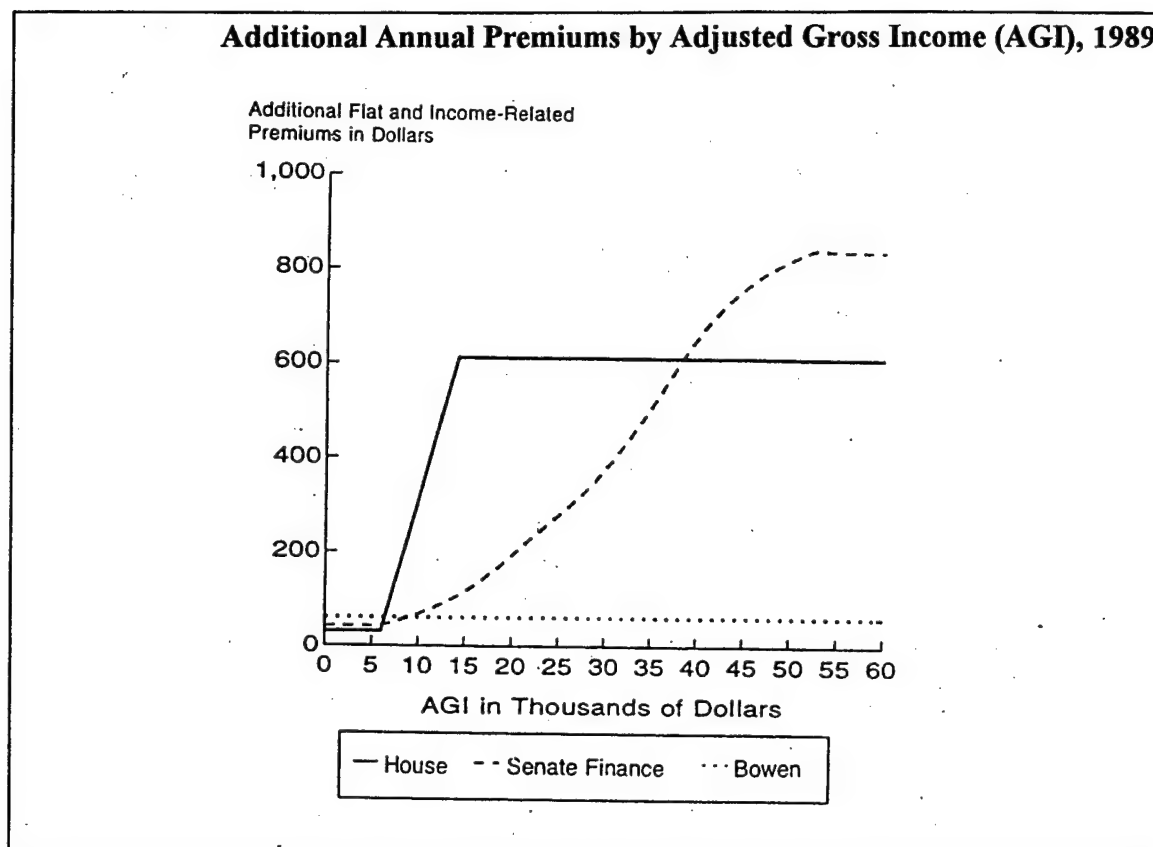


Figure 7. Additional premiums under selected catastrophic plans by adjusted gross income, 1989. (Source: Moon, 1996, p. 114)

2. Senate

a. *Bentsen Bill (S 1127)*

Senate Finance Committee Chairman Lloyd Bentsen (D-TX) introduced S 1127, the Senate's version of catastrophic coverage legislation on May 5, 1987. The bill was similar to the House Ways and Means Committee version of HR 2470, except that it had not yet added the prescription drug coverage. The cosponsors on the bill included all

the Democrats on the Finance Committee plus five of the committee's nine Republicans, including Minority Leader Robert Dole (R-KS). (Rovner, 1987, pp. 1136-37)

The Finance Committee unanimously approved this bill on May 29, 1987. According to the Congressional Quarterly, "The overwhelming bipartisan support for the Senate bill represented something of a personal victory for Bentsen, who has been championing a similar catastrophic care plan since 1984 and has made expanding Medicare coverage a priority since the late 1970's" (Rovner, 1987, p.1136). The financing differed in the Senate bill from the House bill. The Senate's bill made the additional benefits completely optional. Only those enrolled in optional Medicare Part B would be eligible for the new catastrophic coverage. The House bill, HR 2470, on the other hand, expanded benefits systemwide and would require all upper income beneficiaries to pay the supplemental premium, even if they were only enrolled in Part A. Under S 1127, the monthly Part B premium would go up \$4, whereas the House bill would only raise it \$1. The annual supplemental premium under S 1127 would go up to a maximum of \$800, (compared to \$580 in the House bill), but it started at a lower income, spreading out the cost over a wider range of income (see Figure 7). (Rovner, 1987, pp. 1136-37)

The prescription drug issue was not debated in the Senate until after the August recess in 1987. The Administration and many of the Republicans in the Senate, including Minority Leader Robert Dole, were opposed to the addition of the prescription drug benefit to S 1127 (Rovner, 1987, p. 2128).

A bipartisan group of Senators had been working on a drug amendment to S1127 since August, led by Finance members John Heinz (R-PA) and George Mitchell (D-MA), who also chaired the Health Subcommittee. Senator Heinz reached an agreement with the administration over a prescription drug amendment to S 1127 on October 16, 1987. The amendment was very similar to the House Ways and Means committee version of the bill (HR 2470). It would be phased in gradually over 3 years, and would cover 80 percent of the costs of the outpatient drugs after an annual \$600 deductible was paid (Rovner, 1987, p. 2517).

On October 27, 1987, by a vote of 86-11, the Senate approved its version of HR 2470 (with the text of S 1127 inserted), nearly three months after sponsors attempted to bring it to the floor. Later in the same day, Senator Heinz announced on the floor that the administration supported his drug amendment to the bill, and it passed by a vote of 88-9. In late October, 1987, sponsors of the bill were cautiously optimistic that the House-Senate conference committee could complete its work on the bill (HR 2470) and have it on President Reagan's desk for signature by the end of the congressional session in December (Rovner, 1987, pp. 2677-82).

C. PASSAGE OF THE MCCA

1. Pepper-Rostenkowski Debate

Rules Committee Chairman Claude Pepper continued his effort to get his long-term care bill to the House floor for debate. Under the agreement made July 9 with Speaker Jim Wright, Pepper would not offer his long-term care bill as an amendment to

the MCCA, but could bring his measure to the floor on "an appropriate vehicle." In October, 1987, he found his vehicle, and got his bill (HR 2762) attached as an amendment to a minor measure (HR 3436) substituting his bill for its original text. Then on November 17, 1987, the measure came before the Rules Committee for floor submission. Dan Rostenkowski argued that this was not the year to be forcing House members to vote on new spending initiatives. Pepper persisted, and easily won the vote in his own committee. Although Rostenkowski did not want to take this fight to the House floor, he knew that he had a better chance of defeating it there, especially with the current budgetary atmosphere of fiscal restraint. Pepper conceded that the timing wasn't right, and that it would likely be 1988 before the House took the measure up on the floor. (Rovner, 1987, pp. 2874-75)

Throughout the following months, Representative Claude Pepper picked up considerable support from Congress and senior citizen groups for a long-term care bill (HR 3436). Many members of Congress thought that this measure had a good chance of passing, especially since so many of them were up for reelection in 1988. The debate between Pepper and Rostenkowski became a personal turf battle, because Pepper's deal with Wright allowed him to circumvent the system by going around the Ways and Means and Energy and Commerce Committees and going directly to the House floor with his measure. Finally, after months of internal debate and maneuvering, on June 8, 1988, Rostenkowski prevailed by defeating a rule (H Res 466) on a 169-243 vote that would have allowed debate of the Pepper bill (HR 3436) on the House floor (Rovner, 1988, p. 1608).

2. The Conference Committee

The House and Senate started work towards a compromise version of the catastrophic costs bill (HR 2470) in April 1988. The compromise plan would increase the out-of-pocket cost cap (dollar amount) each year by enough to keep the percentage of Medicare beneficiaries that reach it constant, at 7.9 percent. The cost cap is a financial control device that regulates the cost of the program to the government. A beneficiary has to pay all of his/her out-of-pocket costs up to the cap and any Medicare-covered costs above the cap would be paid by the federal government. That is, the higher the cap, the lower the cost to the government because fewer beneficiaries would reach that level of out-of-pocket costs. Likewise, a lower cap means higher cost to the government because more beneficiaries would reach the cost cap that year.

There was also compromise on the financing involving the flat and the supplemental premiums. The agreement was for a 60-40 split between supplemental and flat premiums, i.e., 60 percent of the cost to the government would be paid by the supplemental premium and 40 percent by the flat premium. (Rovner, 1988, p.1169)

After agreement was reached on the prescription drug coverage on May 20, financing and respite-care terms were still not agreed upon. On May 24-25, Bentsen, Dingell, and Rostenkowski agreed to make coverage mandatory, as per the House plan, but move closer to the Senate's plan of financing, keeping constant the percentage of eligible beneficiaries. Respite-care had to be decided at full conference. Bowen made it clear that he was opposed to respite-care because he felt it was a long-term care issue and

did not belong in this debate. Although most of the Senate conferees were against respite-care, Senators Bill Bradley (D-NJ) and Dave Durenberger (R-MN) pushed hard for its inclusion. Bradley offered a proposal that would have limited the benefit by tightening the eligibility standards. Even though Pete Stark was still opposed to the proposal, Bowen made a turn-around and accepted the Bradley offer (Rovner, 1988, pp. 1448-49). By May 25, 1988, the conferees completed work on the compromise version of the catastrophic costs bill (HR 2470). All fear of an administration veto was removed when Secretary Bowen officially approved the plan on the same day.

The House adopted the conference report on June 2, 1988, on a vote of 328-72 (Rovner, 1988, p.1494). The Senate approved it on June 8, 1988, on a vote of 86-11 (Congressional Quarterly, 1988, p.1606). President Reagan signed the MCCA during a major ceremony held in the Rose Garden of the White House on July 1, 1988 (Moon, 1996, p. 115). A summary of the major provisions of HR 2470 approved by the conference committee and signed into law by President Reagan, is provided in Table 1.

D. SUMMARY

The MCCA started as a simple proposal by Secretary Bowen in 1986, embodied as the Bowen plan in the initial bills, HR 1245 and S 492. The Stark-Gradison bills (HR 2180/81) added some benefits to the Bowen plan as well as means-tested financing. A prescription drug benefit was added by the Waxman amendment and the House passed its version on July 22, 1987. The Senate followed a simpler path, since only the Finance Committee had jurisdiction over Medicare. The Bentsen bill (S 1127) was very similar to

the House Ways and Means Committee version, but did not have the drug benefit. The drug provision was very controversial in the Senate, but its bill with a drug amendment added was approved October 27, 1987. The conference committee finished on May 25, 1988, with the House and Senate passing the bill (HR 2470) on June 2 and 8, 1988, respectively.

There were two crucial decisions made in Congress that figured prominently in the development of the MCCA and played a key role in its future repeal in 1989. One was means-testing part of the cost of the benefits and the second was not adding long-term care to the bill.

The next chapter will highlight in detail the financing aspects of the MCCA and its impact on the federal deficit.

Benefits of the MCCA

Medicare Part A

- * **In-patient Hospital Services.** Covers all hospitalization costs for up to 365 days per year after payment of a single annual deductible of \$564.
- * **Skilled-Nursing Facilities.** Extends to 150 days, from 100 days, coverage for qualified stays in a certified skilled-nursing facility (SNF). Eliminated the previous requirement that a patient be hospitalized for three days prior to entering the nursing home.
- * **Hospice Care.** Eliminated the 210-day limit on hospice care if the patient is certified as terminally ill by the attending physician or hospice medical director.
- * **Deductible.** The Part A deductible could also be waived to the extent a beneficiary has already met the deductible under Part B.

Medicare Part B

- * **Cap on Out-of-Pocket Costs.** Limited an individual's out-of-pocket expenses for Medicare-covered Part B services to \$1,370 in 1990. Prior to MCCA, Medicare paid 80 percent of covered costs after payment of a \$75 annual deductible. After the cap is reached, Medicare would cover 100 percent of all covered costs, although doctors could still charge more than the Medicare-approved amount. The cap would have increased annually by a rate designed to hold constant, at 7 percent, the proportion of beneficiaries who reached the cap each year.
- * **Home-Health Services.** Allowed Medicare-covered home-health care services seven days per week for up to 38 days if a physician certifies the need for such care on a daily basis. Prior law allowed only five days per week for no more than 21 days.
- * **Respite Care.** Provided coverage up to 80 hours per year of paid care to give a respite to an unpaid family member or friend who lives with and cares for a "chronically dependent" Medicare beneficiary.
- * **Mammogram Screening.** Provided for biennial screening mammograms for Medicare beneficiaries over 65. Prior law permitted mammograms for diagnostic purposes only.

Prescription-Drug Coverage

Beginning in 1991 Medicare would pay 50 percent of the costs of outpatient prescription drugs after an annual \$600 deductible was met. In 1992, 60 percent of the costs would be covered and in 1993 and thereafter, 80 percent of the costs would be covered. Indexed the deductible to keep constant, at 16.8 percent, the proportion of Medicare beneficiaries who would qualify for the drug benefit.

Table 1. Benefits of the MCCA. (Source: Congressional Quarterly, 1988, pp. 1606-11)

V. MCCA AND THE FEDERAL DEFICIT

A. MCCA FINANCING

In 1988, when HR 2470 passed and was signed into law as the MCCA, it was the largest expansion of Medicare since the program's inception in 1965. It sought to provide a cap for beneficiary out-of-pocket catastrophic costs related to acute illnesses and outpatient prescription-drug costs for the 33 million Medicare beneficiaries. The original mandate from President Reagan directed that any additions to the Medicare program had to be budget neutral. The financing for the MCCA was designed to accomplish that goal. The two financing mechanisms for the MCCA were the means-tested supplemental premium and the addition to the existing flat Part B premium. Congressman J. Roy Rowland, (D-GA), made the following comment after voting for the conference report on June 2, 1988:

If you look at the history of what we have done for the past twenty-odd years in this country, we have never enacted a program for health care that met the budget requirements. It has always cost more than it had projected to, and I see no reason to believe that this will not take place in this instance, also. (Rovner, 1988, p. 1495)

Financing was a key aspect of the MCCA from its inception. Secretary Bowen envisioned a flat premium increase that applied to all beneficiaries. Bowen was against any departure from the universal financing mechanism that Medicare had used since its inception in 1965. The Stark-Gradison bills expanded the benefits beyond the basic Bowen

plan and therefore required an additional source of revenue to finance the new benefits. Congressman Stark used the mean-tested supplemental premium to generate the additional revenue. Although means-testing Medicare was controversial in 1986, it was accepted in 1988, and the means-tested financing plan in the Stark-Gradison bill sailed through Congress without much opposition.

Some elderly, however, were opposed to means-testing Medicare. The means-tested supplemental premium became a rallying point for the segment of the elderly that were against the MCCA, referring to it as the "seniors tax" or even the "AARP tax." Fueled by the National Committee to Protect Social Security and Medicare, the beneficiaries opposing the MCCA became stronger and more vocal as word spread about the supplemental premium and also the front-loaded financing.

The financing for the MCCA was designed to build up a reserve immediately, while the benefits would be phased-in at a slower rate. The payments for the additional premiums for the MCCA started in 1989, but the benefits were not scheduled to be fully in place until 1991 for Parts A and Part B, and not until 1993 for the outpatient prescription drug benefits. This front-loading provision angered the elderly who viewed it as an unfair plan. For example, in 1989, the only major benefit that would be available was the unlimited hospital coverage, which only benefited an estimated 3.8 percent of Medicare beneficiaries. While this financing plan caused all beneficiaries to pay more immediately, less than 4 percent of them would benefit from the new provisions. This problem was one of concern for the conferees on the MCCA. Stated Representative Ron Wyden (D-OR),

during discussion of the drug coverage phase-in, "It's an election year, and there's a growing concern about asking people to pay right away for benefits they're only going to get in the future" (Rovner, 1995, pp. 165-66).

In retrospect, only the flat monthly premium increase of \$4, which went into effect January 1, 1989, was actually paid (deducted from Social Security checks) by the beneficiaries in 1989. The supplemental premium, on the other hand, was to be paid along with the 1989 federal income tax, which was not collected until April 15, 1990. By that time the MCCA had been repealed. (Rovner, 1989, p. 901)

1. Medicare Part A - Supplemental Premium

The mandatory supplemental premium was assessed on the estimated 40 percent of 33 million Medicare beneficiaries with federal income tax liabilities greater than \$150 per year. It was designed to finance 63 percent of the total MCCA costs, with the flat Part B premium picking up the remaining 37 percent. The supplemental premium started in 1989, at the rate of \$22.50 per year on each \$150 of federal income tax liability, up to a cap of \$800 per year. (The estimated supplemental premium schedule for 1988 to 1993 is shown in Table 2.) After 1993, the premium would be indexed to the costs of the catastrophic benefits and prescription-drug programs plus specified contingency reserves. It could rise no more than \$1.50 per year per \$150 of tax liability and the cap could not increase more than \$50 per year. (Congressional Quarterly, 1988, pp. 1606-11)

Medicare Supplemental Premium Schedule for 1988-1993		
Year	Annual Premium/\$150 of Tax	Annual Cap
89	\$22.50	\$800
90	\$37.50	\$850
91	\$39.00	\$900
92	\$40.50	\$950
93	\$42.00	\$1050

Table 2. Supplemental Premium Schedule for 1989-1993. (Source: Congressional Quarterly, 1988, pp. 1606-05)

2. Medicare Part B - Flat Premium Increase

Although Medicare Part B was optional, over 95 percent of the Medicare beneficiaries opted for it, and therefore had to pay the increased Part B premium. All Medicare beneficiaries who had Part B, regardless of income were required to pay this premium. The increase to the existing flat premium was designed to cover 37 percent of the MCCA costs. The premium for 1988 (prior to MCCA), was \$24.80 per month. The premium would increase \$4.00 in 1989, \$4.90 in 1990, \$7.40 in 1991, \$9.20 in 1992, and \$10.20 in 1993, to \$60.50 per month in 1993. (Congressional Quarterly, 1988, p. 1607)

3. MCCA Benefit Schedule, 1989-1993

The MCCA benefits were planned to be phased-in over five years, from 1989 to 1993. Part A (Hospital Insurance) benefits were started in 1989 and planned to be completely in place by 1991. Part B (Supplemental Medical Insurance) benefits were to be started in 1990 and also be completely in place by 1991. The prescription drug benefits

were to be started in 1990 and completely in place by 1993. The MCCA benefit schedule is in the following Table 3.

MCCA Benefit Schedule	
1989	
* Hospital inpatient (Part A), \$560 annual deductible	
* Skilled Nursing Facility (SNF) to 150 days per year, \$25 coinsurance	
* Hospice care , no limit if terminally ill	
1990	
* Home Health benefits, all in place after 1990	
* Part B Cap , \$1370 per year, (the cap increased annually by the amount needed to hold constant, at 7 percent, the proportion of beneficiaries who reach the cap each year)	
* Mammography screening	
* Respite Care , 80 percent of costs for a maximum of 80 hours per year	
* Limited Drug Coverage , \$550 deductible, 50 percent coinsurance required	
1991	
* All Part A and Part B provisions in place	
* Part B Cap , \$1,530 per year	
* Full Drug Benefits , \$600 deductible, 50 percent coinsurance required, (the deductible was indexed to keep constant, at 16.8 percent, the proportion of beneficiaries who would receive the drug benefit)	
1992	
* Part B Cap , \$1700 per year	
* Full Drug Benefits , \$652 deductible, 40 percent coinsurance	
1993	
* Part B Cap , \$1900 per year	
* Full Drug Benefits , \$710 deductible, 20 percent coinsurance	

Table 3. MCCA benefit schedule. (Source: Moon, 1996, p. 117)

B. MCCA AND THE FEDERAL DEFICIT

1. MCCA COST

It was estimated in 1988, that from 1988 to 1993, MCCA would cost \$30.7 billion. The flat and supplemental payment schedules for 1988 to 1993 were designed to cover the cost of the program plus a contingency reserve.

a. Supplemental Premium Surplus

Senator Bentsen stated in April 1989, that the latest revenue estimates show that the supplemental premium would raise nearly \$5 billion more over the next five years than was needed to pay for the new benefits and maintain the legally required contingency and reserve funds. The difference was due to an initial underestimation of the number of senior citizens who actually fell into the income brackets affected by the supplemental premium. (Rovner, 1989, p. 901)

Accordingly, Senator Bentsen suggested to the Treasury Department that the new estimates, "if confirmed, would allow us to reduce the cap on the supplemental premium quite substantially - or to take other measures to reduce the premiums beneficiaries are expected to pay" (Rovner, 1989, p. 901).

Simultaneously, President Bush released a letter to Chairman Rostenkowski stating that "it would be impudent to tinker with Medicare catastrophic insurance literally in its first few months of life...we should not now reopen the legislation" (Rovner, 1989, p. 969). Rostenkowski added in a statement on April 24, 1989, "Revenue-estimating is hardly an exact science, and I urge my colleagues to

carefully consider the points raised by the president before pursuing legislation to amend the act" (Rovner, 1989, p. 969).

In the spring of 1989, Rostenkowski, Gradison and other House members active with the MCCA were uncertain of the revenue estimates and reluctant to tamper with the program. A CBO special study was due in June, 1989, estimating the cost of the prescription drug program and the House leadership recommended a wait and see approach concerning any adjustment to the supplemental premium (Rovner, 1989, pp. 969-70).

One fact that was generally agreed upon in June 1989 was that there would be a sizable surplus resulting from the front-loaded financing of the MCCA that would on paper make the federal deficit appear smaller by the end of 1993. The estimates of the surplus grew as time passed, from \$6.2 billion in January, 1989 (Treasury Department estimate), to \$8 billion in February, 1989 (CBO estimate), and up to \$10 billion in May, 1989 (CBO estimate). (Rovner, 1989, pp. 1329-30)

b. Drug Benefit Cost Increase

On June 26, 1989, Senator Bentsen announced that the latest CBO estimate on the MCCA prescription drug program would indicate that the program would be more expensive than originally anticipated, thus consuming any expected revenue surplus (Rovner, 1989, p. 1782). Later data in September, 1989, revealed that both drug prices and usage of the prescription drug benefit were higher than originally estimated. Lawmakers set the drug benefit cap schedule such that no more than 16.8 percent of the

beneficiaries would qualify for the drug benefit. The estimates in September, 1989, showed that if no changes were made to the MCCA, 26 to 27 percent of beneficiaries would qualify for drug benefit coverage in 1991 (Rovner, 1989, p. 2317). Marilyn Moon states "the (CBO) reestimates of the cost of the drug benefit - using the newly available data - proved twice as high as the original figure" (Moon, 1996, p. 125).

In addition to the drug benefit, the CBO reestimates in 1989 showed that the expansion in the Skilled-Nursing-Facility (SNF) benefit was projected to cost more than six times the original estimate. As one of the first benefits of the MCCA to be implemented, SNF usage jumped dramatically in 1989. In 1989, both the number of days per stay and the number of persons covered rose. (Moon, 1996, p. 124)

2. MCCA Repeal and the Deficit

In September, 1989, after the summer recess, the movement to change MCCA or to repeal it altogether had gained considerable momentum in Congress. The resolution of the MCCA problem posed a dilemma for Congress. They had to do something to pacify their angry constituents, but repealing the program posed a serious budget problem. The CBO estimated in 1989 that eliminating the program would add as much as \$6 billion to the federal deficit in fiscal year 1990. The other options of reducing the supplemental premium or making the program voluntary would have similarly negative effects on the federal deficit. (Rovner, 1995, p. 172)

C. SUMMARY

The financing of the MCCA was initially designed to ensure that the program would be budget neutral. The total cost of the program would be paid by revenues from increased premiums paid solely by the Medicare beneficiaries themselves. The increased revenue to pay for the MCCA would come from two sources, a new supplemental premium and an increase to the existing flat Part B premium.

The new supplemental premium would be means-tested, requiring only about 40 percent of the Medicare beneficiaries to pay it. There was a cap on the amount that the highest income beneficiaries would be required to pay, set at \$800 per year in 1989. The supplemental premium was actually a surtax, due when a beneficiary filed their income tax statement in April of the following year. The supplemental premium was designed to cover 63 percent of the costs of the MCCA program.

The second source of revenue was an increase to the existing flat Part B premium. The over 95 percent of all Medicare beneficiaries who opted for Part B were therefore required to pay the increased premium. The increased premium of \$4 per month started January, 1989, and was deducted from the Social Security check that each beneficiary received at the first of every month. The increased flat premium was designed to cover 37 percent of the costs of the MCCA program.

The premiums for the MCCA program were front-loaded, to initially build up a reserve, while the benefits were phased-in at a slower rate. The combination of a means-

tested supplemental premium coupled with front-loaded premiums produced a backlash of opposition to the MCCA from the middle and upper income Medicare beneficiaries.

In the summer of 1989, momentum grew in Congress to either change or repeal the MCCA. Any reduction or move to repeal the program would result in an increase in the federal deficit due to revenues already received from the flat premium and to lost future revenues. The supplemental premium proved to be extremely controversial among the middle and upper income beneficiaries who were expected to pay it.

The next chapter will chronicle the elements and events that led to the repeal of the MCCA in 1989.

VI. REPEAL OF THE MCCA, 1988-1989

Courage is a commodity that shows its face from time to time on Capitol Hill. I don't think this is one of its greater moments.

- Senator John D. Rockefeller IV, September 1989 (Rovner, 1995, p. 145)

A. PRIMARY REASONS FOR REPEAL

Although the MCCA passed by overwhelming bipartisan majorities in both the House and the Senate and achieved major reform that seemed to have every political advantage, it became a political casualty. "Seventeen months after becoming law and before any of its major benefits took effect, the catastrophic-insurance provision was repealed by Congress. It was a victim of a loud protest from the very people it was supposed to help" (Johnson and Broder, 1996, p. 68).

Criticism and controversy were no stranger to the MCCA. Even the modest Bowen plan was harshly criticized by senior White House aides even before it was introduced to Congress in 1987. There was a constant stream of criticism from both sides of the political spectrum while the MCCA was going through congressional committees in 1987 and 1988. The liberals argued that the measure did not go far enough, that it left out long-term care, the main source of out-of-pocket catastrophic costs. Groups representing the elderly argued that the means-tested (supplemental premium) financing of the MCCA departed from the historically "universal" aspect of the Medicare program. Conversely, conservatives had been critical of the MCCA because it had departed from its original

purpose of simply capping out-of-pocket costs and had become a vehicle for expansion of the Medicare program.

By the time it had passed in June 1988 it was referred by some as the "Christmas tree bill." Congressman Bill Frenzel of the Ways and Means Committee (R-MN), asserted that the original Bowen plan "was severely twisted and distorted as it made its way through House and Senate committees," and ultimately became "a \$30 billion Christmas tree with expensive additions like a prescription-drug benefit and a troublesome tax increase on seniors, many of whom may get no benefit from those extra taxes" (Rovner, 1988, p.1495). Using the same analogy, Marilyn Moon commented, "In a sense, the Catastrophic Act was a Christmas tree bill to which ornaments had been added, the problem was that there were more ornaments than tree" (Moon, 1996, p. 130).

The public and the lobby groups representing the elderly became the harshest critics of the MCCA after it became law. One of these groups, the National Committee to Preserve Social Security and Medicare (Roosevelt group) had been urging members to oppose the MCCA and support Chairman Claude Pepper's measures since 1988. The group objected to the MCCA because it did not provide long-term care, and that it required Medicare beneficiaries themselves to pay for the new benefits through premium increases. The Roosevelt group became a nucleus around which many of the opponents of the MCCA outside Congress and the administration seemed to gravitate. The Roosevelt group was joined by federal government retiree organizations along with many other grass-root groups that formed a critical mass large enough to get the attention of

Congress. Although the vocal segment of the elderly against the MCCA probably represented less than a third of all Medicare beneficiaries, they made a significant impact on Congress because they were organized, motivated, mostly upper income, and the only segment of the public that provided significant feedback to Congress about the MCCA. Those beneficiary groups that had the most to gain from the MCCA (mid to low incomes) were silent, and as Marilyn Moon noted, "persons with lower incomes tend to be less politically active" (Moon, 1996, p. 133).

It has often been said that budgeting in a period of deficit reduction is a zero-sum game. The same can also be said of legislating, that is, the only way to give to some is to take away from others. Julie Rovner commented on this situation concerning the MCCA:

It is axiomatic in politics that those who are or stand to be hurt are much more vocal than those who will benefit. But the need for redistribution will make the losers more apparent and will guarantee an increase in the volume of complaints. In the case of catastrophic coverage, the new benefits did not make enough people happy to counteract the volume of complaints. (Rovner, 1995, p.177)

There were two primary reasons that these elderly were upset and also why the MCCA was repealed less than 18 months after it was signed. The first was the financing mechanism and the second was the lack of long-term care. These two issues were closely linked to each other. The elderly might not have complained as strongly about the financing, if the benefit package was bigger and included long-term care. Likewise, they wouldn't have complained about the lack of long-term care if the financing package did not contain the supplemental premium. Marilyn Moon states, "Certainly the final package

did not represent as dramatic a change on the benefits side as did the financing mechanism intended to pay for the legislation" (Moon, 1996, p. 130). Ways and Means member Bill Frenzel (R-MN) added shortly after passage in 1988, "here is a bill which promises catastrophic coverage, but it comes up with only marginal improvements in the number one problem area (long-term care)" (Rovner, 1988, p. 1495). The elderly felt that it was unfair that they should bear the entire cost of the program. The upper income beneficiaries were upset that they had to pay more than those with lower incomes.

Actually, the benefits did outweigh the costs of the MCCA for the average beneficiary. Even for the upper income senior citizens with medigap insurance paid for them through their current or previous employers, the MCCA was still a good deal (see Table 4).

The CBO simulation assumed the program was fully implemented and estimated the following annual usage rates of the MCCA benefits: 3.8 percent of Medicare beneficiaries, (about 1.3 million people) would use the new Part A coverage (unlimited hospital care), 7 percent of beneficiaries (about 2.1 million people) would use the new Part B benefits (cap on out-of-pocket costs), and 16.8 percent (about 5.6 million people) would use the new prescription-drug coverage (Moon, 1996, p. 120).

The annual net effect of the MCCA on the beneficiary cash flow is displayed in Table 4. The amount received in the form of annual benefit payments would have increased \$194, from \$2,801 to \$2,995. Another positive effect of the MCCA for the beneficiary, was the decrease in copayment liabilities of \$172, from \$731 to \$559 per year.

The only negative effect of the MCCA was the increase in annual Medicare premiums payable of \$207, from \$290 to \$497 per year, primarily due to the supplemental premium. The annual net effect of the MCCA when fully implemented would result in a net positive cash flow of \$159 per year for the average Medicare enrollee. (Moon, 1996, p. 120)

The Annual Net Effect of the MCCA on Beneficiary Cash Flow			
	Before(\$)	After(\$)	Change(\$)
Medicare benefit payment per enrollee (cash in)			
Hospital Insurance (A)	1,693	1,747	54
Supplementary Insurance (B)	1,108	1,191	83
Catastrophic Drug Insurance	0	57	57
Total	2,801	2,995	+194
Medicare copayment liabilities per enrollee (cash out)			
Hospital Insurance (A)	162	118	-44
Supplementary Insurance (B)	325	262	-63
Catastrophic Drug Insurance	244	179	-65
Total	731	559	-172
Medicare premiums payable per enrollee (cash out)			
Flat premiums(B)	290	368	78
Supplemental premiums (A)	0	129	129
Total	290	497	207
Net annual cash flow per enrollee	+1780	+1939	+159

Table 4. The annual net effect of the MCCA on beneficiary cash flow.
(Source: Moon, 1996, p.120)

When income status is compared to net change in beneficiaries' out-of-pocket costs after MCCA, it shows that the middle and lower income groups had a net positive benefit from the MCCA, whereas the upper income beneficiaries incurred increased costs (see Table 5). This data was also derived from CBO estimates assuming full implementation of the MCCA and compared only the increased costs of the MCCA and did not add in the positive effect of benefit payments to enrollees as depicted in Table 4.

Net Change in Enrollees' Out-of-Pocket Costs by Income After the MCCA				
<u>Enrollees' Income and Poverty Status</u>	<u>Percentage of Enrollees in Group</u>	<u>Direct Cost (\$)</u>	<u>Net Change in: Premium Cost (\$)</u>	<u>Total Costs (\$)</u>
Per Capita Income Percentiles (average per capita income)				
0 to 10 (\$2,881)	10.0	-237	80	-158
11 to 30 (\$5,623)	20.0	-221	81	-140
31 to 50 (\$8,575)	20.0	-195	89	-106
51 to 70 (\$12,604)	20.0	-189	157	-32
71 to 90 (\$19,579)	20.0	-171	373	203
91 to 100 (\$52,291)	10.0	-161	597	436
By Poverty Status				
Poor	12.8	-232	80	-152
Near Poor	19.4	-226	79	-147
Other	67.8	-178	268	90
All enrollees	100.0	-194	207	13

Table 5. Net change in enrollees' out-of-pocket costs per income after MCCA.
(Source: Moon, 1996, p. 122)

1. Financing

The financing issue was the single most important reason for the repeal of the MCCA, largely because it caused a very emotional response from upper income Medicare beneficiaries. The Roosevelt group played a large role in stirring the emotions of the elderly against the MCCA through their mass mailings calling for beneficiaries to "act now to save their Medicare benefits" (Murphy, 1988, pp. 1310-13). The Roosevelt group also warned the elderly that the MCCA would make them pay an additional \$800 a year for the supplemental premium. The group not only distributed a lot of misleading information about the MCCA, but also played on the basic lack of knowledge possessed by most beneficiaries about the financing and benefits of the Medicare program. The group's activities had been the subject of many congressional hearings and had been criticized repeatedly by members of both parties in Congress (Rovner, 1988, p. 777).

By January, 1989, the mail in Congress had become heavy from beneficiaries protesting the supplemental premiums. On January 13, 1989, the new Senate Majority Leader George Mitchell (D-ME), a key sponsor of the MCCA, issued this statement in response to complaints received about the MCCA, "the progressive, income-related financing method is a sincere attempt to provide an equitable way to distribute the burden of additional costs of expanded benefits fairly among the elderly population" (Rovner, 1989, p. 86). House Ways and Means Chairman Dan Rostenkowski (D-IL), added, "It would be a tragedy if this legislation is undone by a vocal minority of the elderly

population who are focusing solely on the financing of the program to the exclusion of the significant insurance benefits that they receive" (Rovner, 1989, p. 86).

The most vocal opponents to the MCCA were those who had to pay the supplemental premium and also those who thought they had to pay it. The AARP, the primary outside backer of the MCCA, released the results of a public opinion poll showing that those over the age of 65 supported the new law by a margin of more than 2-to-1 (Rovner, 1989, p. 86). These results correspond with the ratio of beneficiaries who would not have to pay the supplemental premium to those who would, about one to three.

Many of the MCCA's supporters in Congress at this point were in denial, hoping that the noise over the bill would all blow over soon, but it just kept getting worse. In January, 1989, two other groups, the National Association of Retired Federal Employees and the Retired Officers Association joined the Roosevelt group in opposition to the MCCA. After announcing another mass mailing to 3 million of their members, a spokesman for the Roosevelt group conceded that changing the law would be an uphill battle because, "Nobody wants to admit he made a mistake, least of all the Congress" (Rovner, 1989, p.86).

The beginning of the end for the MCCA came in the spring of 1989 when the Treasury Department announced that the revenues from the supplementary premium were expected to produce a \$6 to \$10 billion surplus by 1993. Senator Bentsen interpreted this as good news and announced that he would recommend lowering or postponing the supplemental premium. The news of a revenue surplus only made those already

disgruntled beneficiaries even more angry. Not only were they paying more for a benefit that they didn't want or need, but they were paying for a surplus which was being used to offset the federal deficit. Then a month later, it got worse, the CBO announced that the new prescription drug and the skilled nursing facility benefits were going to cost two and six times, respectively, more than originally estimated. This would effectively wipe out the revenue surplus, so instead of premiums coming down, as suggested by Senator Bentsen, they would have to go up, to keep the program afloat and budget neutral. Representative Bill Gradison commented on April 25, 1989, "It's reached the point in my town where I don't refer to this (MCCA) as the Stark-Gradison bill any more - I refer to it as the Stark bill" (Rovner, 1989, p. 969).

By June, 1989, many members of Congress were swamped by complaints from angry beneficiaries. Senator John McCain (R-AZ), sponsored a bill (S 335) to delay most of the new benefits and testified that of the 20,000 letters his office had received about MCCA, "not more than 10 had indicated support." Many in Congress did not realize how hostile public sentiment was until they went back to their constituencies during summer recess. The summer recess changed many of the supporters in Congress into opponents. In August, 1989, Dan Rostenkowski had his famous run-in with the angry mob at a town meeting in his home district, an incident which culminated in an elderly woman beating the hood of his car with a cane, in full view of national television cameras.

The financing of the MCCA, particularly the means-tested aspect, was the main source of discontent from the upper income elderly. Even if they didn't have to pay an

increased premium because of their income, the mere fact that someday they may have to pay one violated their view that they shouldn't have to pay more for their Medicare benefits. They felt that they had already earned these benefits and were therefore "entitled to them." This was the generation who struggled through the Great Depression and fought in World War Two, and the thought of paying a "seniors only" tax for an entitlement that they had earned, seemed grossly unfair (Rovner, 1989, pp. 2712-15).

2. Long-Term Care

One of the concessions that Congressman Claude Pepper won in his battles over long-term care was the creation of a commission (the so-called the Pepper Commission) to study the issues of long-term care and access to health care for the uninsured. The commission's membership read like a "Who's Who" in congressional health policy and contained six members each from the House and Senate, plus three appointed by the administration. Some of the more prominent members from Congress were Representatives Pepper, Stark, Gradison, and Waxman, and Senators Kennedy, Rockefeller, Durenberger, Pryor, and Heinz.

The creation of this commission relieved some of the criticism about the lack of long-term care in the MCCA because it was tasked to find a solution to the long-term care problem. However, the one limited, long-term care benefit in the MCCA, the Skilled Nursing Facility (SNF) benefit, was being used at a much higher rate than originally estimated. The CBO estimated that the SNF benefit would cost six times more than originally estimated (Rovner, 1989, p. 2317). Rovner commented, "Ironically, since many

of the protesters complain that the program does not do enough to help with long-term care, it is the long-term care benefit (SNF) that is threatening to push the program from black ink into red" (Rovner, 1989, p. 2317).

The lack of long-term care, the coverage most wanted and needed by seniors, was the crux of the McCain-Hatch argument against the MCCA. Senator McCain stated in June, 1989:

Poll after poll, letter after letter, message after message I get from the seniors of this country and from my home state of Arizona is that they want long-term protection. And they cannot get it if we are going to spend almost every available penny on the benefits in this legislation. How in the world are we going to get a long-term health care plan when we have basically drained the resources dry of senior citizens in this country for catastrophic health care coverage? (Rovner, 1989, p. 1401)

3. Secondary Issues

There were a whole host of other issues that contributed to the demise of the MCCA, but three of them stand out. First, this bill was so comprehensive and detailed, that only a handful of Congressman directly associated with the measure could explain its costs and benefits. This was a big problem because the MCCA directly affected a significant constituency base of every member of Congress. There was a large amount of misinformation put out by the Roosevelt group and others that only exacerbated the confusion and lack of awareness on the MCCA.

Congress could have possibly prevented this backlash against the MCCA if they had proactively educated the elderly about the benefits of the MCCA, and its impact on

the Medicare program. The period during which the MCCA was going through conference committee, the spring and summer of 1988, would have been an ideal time to start "advertising" the MCCA since the primary benefits and financing mechanisms had been hammered out.

The confusion over the impact of the MCCA on the elderly was further complicated by the general lack of knowledge of the benefits and the financing of the Medicare program itself. For example in 1988, 80 percent of the beneficiaries believed that Medicare provided long-term care. As Representative Brian Donnelly (D-MA) said about the MCCA, "The disinformation campaign was more successful than the information campaign was" (Rovner, 1989, p. 1860). Another secondary problem was that MCCA duplicated some of the benefits that many of the beneficiaries already had through their medigap policies (Rovner, 1989, p. 1401).

Lastly, the benefits of the MCCA were spread so thin that they seemed insignificant to the average beneficiary. The MCCA lacked focus on any major aspect of health care. It started out with focus, capping out-of-pocket costs associated with lengthy hospital stays, but quickly lost it as the additional benefits were added on. It might have been more popular with the elderly if it stayed small, with a defined focus, such as a limited long-term care package. But in the end it tried to do too much while appearing to actually do very little.

The MCCA was also about an insurance plan to protect the elderly in case something "catastrophic" happened. It was an insurance benefit, which may never be needed. But the price of it - the increased premium, was quite real, and unpleasant.

B. THE REPEAL OF THE MCCA

The House was trying to weather the storm concerning the MCCA and keep the bill intact. The Senate on the other hand, was actively pursuing alternatives in an attempt to squelch the criticism from the elderly over the MCCA. The bill (S 335) sponsored by Senators McCain (D-AZ) and Hatch (R-UT) to delay most of benefits and also collection of the supplemental premium was narrowly prevented from an up-or-down vote by an amendment from Senate Majority Leader George Mitchell (D-ME) and Majority Leader Bob Dole (R-KS) in June 1989 (Rovner, 1989, p. 1400). Officially, the Bush administration was still backing the MCCA, but "made no discernible effort to defeat the McCain-Hatch amendment" (Rovner, 1989, p. 1400).

Senators Mitchell and Dole mounted a last ditch effort to save the MCCA from dismantlement, but their support was dissolving in the Senate. Apart from members in the Finance Committee, only Alan Simpson (R-WY), William Cohen (R-ME), and James Jeffords (R-VT) provided Republican support for the MCCA in the Senate (Rovner, 1989, p. 1400).

Pressure was mounting, for Republicans in Congress because their core constituency included the well-to-do elderly who were screaming the loudest against the MCCA. But a growing number of liberal Democrats were splitting the party on the issue,

joining the Republicans against the MCCA. They argued that the supplemental premium unfairly asks the affluent elderly to subsidize the less fortunate, rather than spreading out the costs like most other social programs (Rovner, 1989, p. 1401).

While the Senate was actively pursuing its options trying to resolve the MCCA debate such as reducing the supplemental premium, reducing the benefits, or making the MCCA optional, the House was trying to hold fast in support of the MCCA. However, some of its members were speaking out against the MCCA. Representative Brian Donnelly (D-MA), one of those who originally supported the bill and also one of its most ardent defenders, now pushed for its repeal. Representative Donnelly said on July 11, 1989, "If senior citizens really want the program to go away, then fine, we'll make it go away" (Rovner, 1989, p. 1781).

The House Ways and Means Committee, while working on the budget reconciliation package, spent much of its time rejecting proposals to amend or repeal the MCCA. The must-pass reconciliation bill was forcing the House leadership to do something about the MCCA. Brian Donnelly (D-MA) offered a repeal proposal on July 20, 1989 to the Ways and Means Committee which was rejected by a 13-23 vote. Meanwhile Chairman Rostenkowski offered a reduced supplemental premium idea and Senator Bentsen offered to drop the drug benefit. Gradison's idea was to make the coverage voluntary, the same direction that the Energy and Commerce and Senate Finance Committees were going. On July 25, the Ways and Means Committee approved, by the narrow margin of 19-17, a Stark-Gradison compromise proposal to halve the

supplemental premium and permit beneficiaries to opt out of the MCCA coverage if they also drop their Part B coverage. This proposal was backed by the Bush administration and the AARP, but many in Congress gave it a thumbs-down because the voluntary choice was not really a choice, since few beneficiaries would actually give up their Part B benefits. Representative Donnelly remarked, "I don't think this (Stark-Gradison proposal) puts the fire out - it does cut the surtax (supplemental premium) but there's nothing voluntary about it - it's about as voluntary as a prison sentence" (Rovner, 1989, p. 1959). The critics of the Stark-Gradison plan were joined by the National Committee for the Preservation of Social Security and Medicare (Roosevelt group) and the National Association of Retired Federal Employees (NARFE) who wanted outright repeal of the MCCA (Rovner, 1989, p. 1959).

In September, 1989, Congress returned from summer recess, motivated to do something about the overwhelming criticism that they all received on the MCCA. Even the MCCA's strongest supporters were saying in September, 1989, that alteration to the MCCA was required if repeal was to be averted. The Bush Administration was still backing the MCCA, but stated on September 7, that it would consider any options that were revenue neutral. The Office of Management and Budget (OMB) deputy director stated that the administration was firmly against repeal, which would cost anywhere from \$4 to \$7 billion because premiums were already being collected for benefits not yet in force (Rovner, 1989, pp. 2316-17).

The House then took the lead towards repeal with Ways and Means Committee members Donnelly (D-MA) and Archer (R-TX) leading the charge. They demanded that the Rules Committee permit them to offer their repeal plan in place of the previously approved Stark-Gradison compromise plan. Meanwhile, the Senate was still searching for an alternative measure to keep the MCCA alive. Health and Human Service Secretary Louis Sullivan reiterated the Bush administration position that no change is preferable, but since some change is inevitable it must be "good health policy, revenue-neutral, and politically stable" (Rovner, 1989, p. 2465). The Senate Finance Committee had no consensus on a compromise plan, with only Senators William Roth (R-DE) and John Danforth (R-MO) actively pushing for repeal (Rovner, 1989, pp. 2463-65).

Although the House had three major options to choose from when it voted on the future of the MCCA on October 4, 1989, most of the members were locked into repeal. The first option, from the Ways and Means Committee, cut premiums and benefits. The second option was the Stark-Gradison-Waxman plan which cut the supplemental premium and most benefits, except drugs and mammograms. The last option was the Donnelly-Archer repeal plan which only kept the Medicaid expansion benefits in the MCCA. Both the Stark-Gradison and the Donnelly-Archer plans would require a budget waiver because of their negative deficit effect of about \$4 billion on the fiscal 1990 budget.

The House voted 360-66 on October 4, 1989 for the Donnelly amendment to repeal most of the MCCA and appended it to the omnibus budget reconciliation bill for fiscal 1990 (Rovner, 1989, pp. 2635-38).

Ironically, the MCCA passed by an overwhelming margin in 1988, and was also repealed by an equally wide margin in 1989, by many of the same members that voted for it 18 months earlier. Bill Gradison said that his colleagues saw no risk in voting for repeal because "There weren't people on the other side saying, 'Hey, don't take it away'" (Rovner, 1989, pp. 2635-38). Two days later, on October 6, the Senate voted 99-0 to repeal the supplemental premium and most of the new benefits but to preserve unlimited hospital coverage and some smaller benefits under a plan crafted by Senator McCain.

For the next six weeks, the House reaffirmed its position to repeal the MCCA, the Senate was still trying to work out some sort of compromise to fend off repeal and the Bush administration was playing both sides and did not take a position. Finally on November 17, during a meeting between House and Senate conferees, Bentsen persuaded Senate conferees to accept repeal. With help from Senator Dole, Senator McCain staged a last ditch effort against repeal, but their plan was rejected on November 21 by the Senate and they backed down. At 1:52 a.m., November 22, 1989, with only a handful of members left in the chamber, the Senate by unanimous consent cleared legislation to repeal the MCCA (Rovner, 1989, pp. 3238-39).

C. SUMMARY

The MCCA was surrounded by criticism and controversy from the beginning. The elderly were against the law for two primary reasons, the financing mechanisms, specifically the supplemental premium and the lack of long-term care benefits. These two issues were linked to each other. If there was not a supplemental premium they would not

have complained about the lack of long-term care; conversely, if there was long-term care, they would not have complained about the supplemental premium. Essentially they were angry about paying for a benefit that they did not want. The segment of the Medicare beneficiaries that complained the loudest was those who were in the upper income bracket and therefore had to pay the supplemental premium and were also paying for benefits that they already had through their medigap policies.

There were several secondary reasons why the MCCA failed. The law was very complex, with widespread lack of understanding and misinformation regarding the benefits and the financing of the MCCA and Medicare in general. The MCCA duplicated some benefits for a small percentage of the beneficiaries and they thought that it was a bad deal. In fact, the MCCA was a good deal, even for those who had duplicated benefits, but they did not realize it. The misinformation was perpetuated by various lobby groups, with the largest, the National Committee to Preserve Social Security and Medicare playing a major role by persuading thousands of elderly to pressure Congress to repeal the MCCA.

A critical aspect of this law was the poor communication between Congress and the elderly. Congress thought that they were delivering what the elderly wanted and were puzzled by the strong negative response that the MCCA evoked. They never really asked them what they wanted and Congress subsequently did a poor job educating the public on the benefits and the financing of the MCCA. Accurate, timely information would have helped decrease the misinformation that filled the void of information about the law.

Lastly, the MCCA became a "Christmas tree bill" with more ornaments than tree. There were so many benefits that they had the effect of being spread thinly across the beneficiary population, and therefore having minimal impact on the average beneficiary. The MCCA lacked a cohesive mission and focus. It started out as simply a cap on out-of-pocket acute care costs and was transformed into a vehicle with many disassociated benefits. Linked to this weakness was the notion that the MCCA was basically an insurance program. It was there when catastrophic illness struck, but hopefully one would never need it.

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In late November, 1989 the Bush administration took no official position on whether to preserve or repeal the MCCA. On one hand, Health and Human Services

Secretary Louis Sullivan personally lobbied to preserve as much of the MCCA as possible. On the other hand, when the options came down to either the modified McCain plan or repeal, President Bush indicated that he would sign whatever came to his desk. Representative Pickle (D-TX) commented, "The White House said that they would sign this bill (McCain plan) - of course, now they said they would sign repeal, too - I guess they don't have a dog in this fight" (Rovner, 1989, p. 3239).

The only benefits that remained were those for low income beneficiaries to have the states pay all Medicare premiums for Medicaid coverage for those who do not qualify for Medicaid. There was also a requirement that states make eligible for Medicaid pregnant women and infants up to one year of age in families with incomes below the federal poverty level. (Rovner, 1989, pp. 3238-39).

In the end, the largest Medicare expansion since its inception was repealed less than 18 months after enactment.

VII. SUMMARY AND CONCLUSIONS

There is nothing more difficult to carry out, nor more doubtful of success, nor dangerous to handle, than to initiate a new order of things. For the reformer has enemies in all these who profit by the old order, and only lukewarm defenders in all those who would profit by the new order...

-Machiavelli (Johnson and Broder, 1996)

A. SUMMARY

The 100th Congress passed the 1988 Medicare Catastrophic Coverage Act (MCCA) in an effort to provide seniors with protection from catastrophic medical costs. The bill was signed into law by President Reagan on July 1, 1988 (P.L. 100-360). The MCCA was then repealed by Congress on November 22, 1989, less than 18 months after it was enacted. The controversial program became politically unpopular after thousands of senior citizens protested having to pay a surtax and higher monthly premiums to finance the new Medicare benefits. Despite efforts by both political parties to save the MCCA, political considerations forced its demise.

The MCCA marked a turning point in Medicare financing policy. It sought to expand Medicare benefits by requiring beneficiaries themselves to fund the additions to the program. Moreover, it was also the first attempt at means-testing a portion of Medicare paid for by the beneficiaries. The MCCA was largely financed by middle and upper income beneficiaries (i.e., it was means-tested). The financing of MCCA became the most controversial aspect of this legislation and the primary reason for its repeal in 1989.

The fiscal and political environment that existed in the mid 1980's was central to the genesis and development of the MCCA. Two opposing forces shaped the political and legislative action during the second term of the Reagan Administration. First, the optimism from a growing, vibrant economy created an atmosphere supportive of increased federal spending, particularly for defense. Second was the countering force of fiscal constraint in response to the rapidly growing federal deficit, as evidenced by the passage of the Gramm-Rudman-Hollings Act of 1985. The desire to divert some of the flowing Reagan defense dollars to increased domestic spending was kept in check by attempts to balance the budget. This balance of forces was upset when the Democrats, who regained control of Congress in 1986, saw a green light for increased domestic spending.

Additionally, the Reagan appointment of Otis Bowen as the new HHS Secretary in 1985 was key to the momentum that the MCCA created. Highly respected, motivated, and aggressive, Secretary Bowen released the Bowen Commission Report in 1986, receiving widespread approval from Congress. The Reagan Administration reluctantly endorsed the Bowen report over two months later, with the stipulation that any additions to the Medicare program would have to be budget neutral. The catastrophic coverage bill had broad support from both parties, but there was a strong push from some liberal Democrats for even more extensive Medicare reform.

There were four major groups involved in shaping the MCCA. They were the Congress, the Administration, lobby groups, and the public. The first two groups, Congress and the administration, were the primary forces responsible for the creation and

passage of the MCCA. The last two groups, the lobby groups and the public, had the strongest influence on the repeal of the MCCA.

In the House, the Ways and Means and the Energy and Commerce Committees and their respective Health Subcommittees had jurisdiction over Medicare and had the most influence over the shape of the MCCA. The key players in the House were Representatives Dan Rostenkowski (D-IL), Claude Pepper (D-FL), Pete Stark (D-CA), Bill Gradison (R-OH), and Henry Waxman (D-CA). In the Senate, the Finance Committee, chaired by Senator Lloyd Bentsen (D-TX), had sole jurisdiction over Medicare. The prominent figures in the Senate were Senators Lloyd Bentsen, George Mitchell (D-ME), John Heinz (R-PA), and John McCain (R-AZ).

Two administrations were involved in the MCCA, President Reagan, who signed it into law and President Bush, who signed the law (HR 3607; PL 101-234) that repealed it. Secretary Bowen was the dominant force responsible for creating the MCCA. President Reagan selected Dr. Otis Bowen as his Secretary of the Health and Human Services Department and also endorsed the Bowen plan for Medicare, despite the objections of his senior aides. President Bush, on the other hand, provided very little support to save the MCCA from repeal.

The lobby groups that influenced the MCCA were a heterogeneous mix. Three categories could be identified: those that represent the beneficiaries, those that represent the health care professionals, and those that represent the "for-profit" health industry, mostly insurance and drug companies. Most of these lobby groups were against the

MCCA and played a strong role in its repeal, most notably the National Committee to Preserve Social Security and Medicare (Roosevelt Group) and the Pharmaceutical Manufacturer's Association (PMA).

The public were in favor of increased spending for the Medicare program, but they were against any attempts to increase the premiums or copayments that beneficiaries would have to pay. Additionally, they were opposed to any plan that would deviate from the universal benefit aspect of Medicare by means-testing or relating premium payments to beneficiary income level .

The MCCA started as a simple proposal by Secretary Bowen in 1986, embodied as the Bowen plan in the initial bills, HR 1245 and S 492. The Stark-Gradison bills (HR 2180/81) added some benefits to the Bowen plan as well as means-tested financing. A prescription drug benefit was added by the Waxman amendment and the House passed its version on July 22, 1987. The Senate followed a simpler path, since only the Finance Committee had jurisdiction over Medicare. The Bentsen bill (S 1127) was very similar to the House Ways and Means Committee version, but did not have the drug benefit. The drug provision was very controversial in the Senate, but its bill with a drug amendment added was approved October 27, 1987. The conference committee finished on May 25, 1988, with the House and Senate passing the bill (HR 2470) on June 2 and 8, 1988, respectively.

There were two crucial decisions made in Congress that figured prominently in the development of the MCCA and played a key role in its future repeal in 1989. One was

means-testing part of the cost of the benefits and the second was not adding long-term care to the bill.

The financing of the MCCA was initially designed to ensure that the program would be budget neutral. The total cost of the program would be paid by revenues from increased premiums paid solely by the Medicare beneficiaries themselves. The increased revenue to pay for the MCCA would come from two sources, a new supplemental premium and an increase to the existing flat Part B premium.

The new supplemental premium would be means-tested, requiring only about 40 percent of the Medicare beneficiaries to pay it. There was a cap on the amount that the highest income beneficiaries would be required to pay, set at \$800 per year in 1989. The supplemental premium was actually a surtax, due when a beneficiary filed their income tax statement in April of the following year. The supplemental premium was designed to cover 63 percent of the costs of the MCCA program.

The second source of revenue was an increase to the existing flat Part B premium. The over 95 percent of all Medicare beneficiaries who opted for Part B were therefore required to pay the increased premium. The increased premium of \$4 per month started January, 1989, and was deducted from the Social Security check that each beneficiary received at the first of every month. The increased flat premium was designed to cover 37 percent of the costs of the MCCA program.

The premiums for the MCCA program were front-loaded, to initially build up a reserve, while the benefits were phased-in at a slower rate. The combination of a means-

tested supplemental premium coupled with front-loaded premiums produced a backlash of opposition to the MCCA from middle and upper income Medicare beneficiaries.

In the summer of 1989, momentum grew in Congress to either change or repeal the MCCA. Any reduction or move to repeal the program would result in an increase in the federal deficit because revenues had already been received from the flat premium and were anticipated in future budgets. The supplemental premium proved to be extremely controversial among middle and upper income beneficiaries who were expected to pay it.

The MCCA was surrounded by criticism and controversy from the beginning. The elderly were against the law for two primary reasons, the financing mechanisms, specifically the supplemental premium, and the lack of long-term care benefits. These two issues were linked to each other. If there was not a supplemental premium they would not have complained about the lack of long-term care; conversely, if there was long-term care, they would not have complained about the supplemental premium. Essentially they were angry about paying for a benefit that they did not want. The segment of the Medicare beneficiaries that complained the loudest was those who were in the upper income bracket and therefore had to pay the supplemental premium and were also paying for benefits that they already had through their medigap policies.

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In fact, CBO data indicate that the MCCA was a good deal, even for those who had duplicate benefits. Misinformation was perpetuated by various lobby groups, with the largest, the National Committee to Preserve Social Security and Medicare, playing a major role by persuading thousands of elderly to pressure Congress to repeal the MCCA.

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After repeal, the only benefits that remained were those for low income beneficiaries to have the states pay all Medicare premiums for Medicaid coverage for those who do not qualify for Medicaid. Also remaining in the repeal bill (HR 3607) was the provision that states make eligible for Medicaid pregnant women and infants up to one year of age in families with incomes below the federal poverty level (Rovner, 1989, pp. 3238-39).

In the end, the largest Medicare expansion since its inception was repealed less than 18 months after enactment.

B. CONCLUSIONS

Medicare reform is inevitable with the graying of the baby-boom generation. With the number of Medicare beneficiaries increasing and the number of workers decreasing, we are facing a fiscal train wreck which will severely impact the country's ability to reduce the deficit unless major Medicare reform is implemented within the next ten years. There are three lessons from the MCCA experience that should be applied to future Medicare reform initiatives.

First, an informed public is the key to success. The administration and Congress should educate the public to ensure that there is understanding of the fundamental fiscal and social implications of any new Medicare reform legislation for the current program and also their private medigap policies. All parties need to understand the positive and the negative consequences of reform, and there must be a public perception that there is value-added by the new legislation for it to be successful.

Second, any change to the Medicare program should be done in small, focused steps. When the initiative becomes a complex, bloated, "omnibus" bill, it is much too difficult to digest by all parties involved. With a large, disjointed, and complex bill, it impedes the communication of the effects to all the stakeholders in the process.

Third, the Medicare beneficiary population is a heterogeneous group and will become even more so in the future. We have to recognize this fact and structure Medicare so that it fits the needs of all of the Medicare beneficiaries. This will mean that we have to depart from the universal paradigm, i.e., a program that provides the same benefits for all

for the same price. We have to accurately determine what the public wants from the Medicare program. We'll most likely find that there are many different needs, based largely on the income level of the beneficiary. As noted by Julie Rovner, "This culture of entitlementalization not only makes it difficult to address health policy issues, but it also makes it increasingly hard to address the deficit, which complicates social policymaking in general" (Rovner, 1996, p. 175).

Finally, because of the sometimes ugly generational politics that arises with trying to shift Social Security and Medicare from a defined benefit to a defined contribution, significant reform will have to wait for the baby boomers, who may better understand the fiscal realities of these "mandatory" programs.

C. RECOMMENDATIONS FOR FURTHER RESEARCH

Following the assumption that Medicare policy reform will be required to balance the federal budget and reduce the deficit, several areas need to be researched.

First, an analysis of the specific health care needs of current Medicare beneficiaries by income level. This would survey the benefits that the elderly are receiving through medigap policies and what needs are not satisfied through these policies.

Second, the role of Medical Savings Accounts (MSAs) needs to be explored in a cost/benefit analysis, both from a beneficiary and an industry perspective. The underlying concern of any government program that overlaps industry practices, such as MSAs, is that it will hurt competition and drive up prices in the private sector.

Third, long-term care costs should to be examined through a cost/benefit analysis of various private and public long-term care options. Long-term care is a growing necessary requirement for the elderly that will become a significant part of both individual and national health care costs as the baby boom generation reaches retirement age.

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